Research Portfolio Submitted in Part Fulfilment of the requirements for the Degree of Doctorate in Clinical Psychology

Rebecca Emily Sired

Doctorate in Clinical Psychology

University of Bath

Department of Psychology

June 2019

Word Counts

Literature Review…… 7650

Service Improvement Project…… 5328

Main Research Project…… 5248

Executive Summary…… 839

Connecting Narrative…… 2877

Table of Contents

Table of Tables

Table of Figures

Critical Review of the Literature

Making Sense of Unhelpful Service Reactions to People with a Diagnosis of 'Borderline Personality Disorder': A Conceptual Review

Rebecca Sired
Doctorate in Clinical Psychology
Department of Psychology, University of Bath, Claverton Down,
Bath, BA2 7AY
r.sired@bath.ac.uk

June 2019

Word count*:* 7605 words

Internal Supervisor: Dr Catherine Butler, Senior Lecturer and Clinical Director, Doctorate in Clinical Psychology Programme, Department of Psychology, University of Bath, C.A.Butler@bath.ac.uk

External Supervisor: Dr Megan Wilkinson-Tough, Clinical Psychologist, Avon and Wiltshire Mental Health Partnership NHS Trust, megan.wilkinson-tough@nhs.net

Proposed Journal for Publication: Personality Disorders: Theory, Research and Treatment, selected as it publishes a wide range of research on personality disorders including integrative conceptual articles which synthesise the research literature (see Appendix A).

Abstract

Interactions between services and people given a diagnosis of borderline personality disorder are often difficult and produce strong reactions for both parties. Problematic staff attitudes towards this group and service user experiences of stigmatising and discriminatory treatment are established within the literature. Policy supports the need for mental health services to work more effectively with this group, however there is currently no framework to help staff make sense of these difficulties, with existing models offering only descriptive or partial understandings. This conceptual review aims to synthesis relevant literature regarding interpersonal core processes related to borderline personality disorder which may be mirrored within care relationships, and staff and service-level factors which may contribute to the problem. Service mirroring of early patterns of care, difficulties mentalising and struggling to tolerate strong emotions are proposed as part of the problem and related evidence considered. The potential role of stigma, challenges to therapeutic optimism, service mis-attunement and lack of staff training and supervision is discussed. These elements are presented within a model, aiming to provide a framework to help staff to make sense of these dynamics. Directions for future research to test these ideas where evidence is lacking is considered and implications for clinical practice are discussed, including the need for sufficient service resourcing, staff training and supervision.

Keywords: Borderline Personality Disorder, Service Reactions, Therapeutic Relationships, Conceptual Review

Outline of the Review

Many people with a diagnosis of borderline personality disorder (BPD) find themselves in regular contact with services, particularly mental health (Swartz, Blazer, George, & Winfield, 1990) and primary care services (Moran, Jenkins, Tylee, Blizard, & Mann, 2000). Interactions between mental health staff and service users (SUs) with this diagnosis often present difficulties and provoke strong reactions for both parties and within the wider system around them. Staff describe finding this group harder to work with than other presentations (Cleary, Siegfried, & Walter, 2002; Markham & Trower, 2003). Up to 50% express a preference to avoid working with people with this diagnosis (Black et al., 2011) and negative attitudes towards them are common (Dickens, Lamont, & Gray, 2016; Sansone & Sansone, 2013). People with BPD diagnoses have reported experiencing stigmatising and judgmental attitudes from mental health staff (Fallon, 2003; Veysey, 2014). Whilst evidence for this often difficult relationship between services and people with BPD diagnoses is established in the literature (Dickens et al., 2016; Westwood & Baker, 2010), and government policy supports the need to work more effectively with this group (DOH, 2009; NIMHE, 2003), there is currently no way for services to conceptualise these dynamics.

This conceptual review aims to draw together existing literature on interpersonal and systemic factors which may be involved in the unhelpful interplay between people with a diagnosis of BPD and services to create a model to better understand this. This approach does not intend to be exhaustive or demonstrate probative value but rather selectively identify relevant theories to offer possible explanations of this issue (see Appendix B). Firstly, evidence of the problem is presented, and relevant existing models discussed. Secondly, interpersonal and systemic factors which may contribute to this are proposed based on themes within the literature, clinical experience of the supervisory team and feedback from limited consultation with people with personal and professional experience of BPD. The theoretical basis for each element, its potential relation to the problem, and associated literature is presented and critiqued, and implications for further research and clinical practice are discussed. It is hoped that an increased understanding of these dynamics will aid improvements in the experience of receiving and providing care for people with difficulties related to this diagnosis.

Borderline Personality Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM V) lists persistent impairment in personality functioning (self-identity and interpersonally) and pathological personality traits across situations and time as key criteria for a diagnosis of personality disorder (APA, 2013). This diagnosis is one of the most controversial (Haigh, 2006), and its' validity and usefulness have both been questioned (Tyrer, 1999). It has been argued that diagnostic thresholds represent an arbitrary cut-off on a continuum of personality traits present within the general population, supported by taxometric studies suggesting BPD is not a latent category (Edens, Marcus, & Ruiz, 2008; Rothschild, Cleland, Haslam, & Zimmerman, 2003). Beyond issues of reliability, other critiques include the pathologising of understandable responses to complex trauma and adverse early experiences (MacIntosh, Godbout & Dubash, 2015). Personality disorder has previously been referred to as a "dustbin diagnosis" for people in services who do not fit within other diagnostic categories (Pilgrim, 2001).

Borderline personality disorder (BPD) is a type of personality disorder listed in the DSM V (APA, 2013). This label is used to describe people with difficulties in interpersonal relationships (relating to and trusting others), emotion regulation (extreme mood fluctuations) and/or an unstable self-identity (APA., 2013). The diagnosis of BPD was initially developed to refer to people considered 'on the borderline' of psychosis and neurosis (anxiety) who did not fit in either category (Stern, 1938). Other details about the term's origins are poorly understood and it has been criticised for having substantial overlap in symptomatology with other disorders (Lewis & Grenyer, 2009; Ramon, Castillo & Morant, 2001).

Prevalence rate estimates vary between 0.7- 2% in the general population (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Torgersen, Kringlen, & Cramer, 2001), increasing to 24% in primary care samples (Moran et al., 2000) and much higher rates reported in secondary care mental health services (Beckwith, Moran, & Reilly, 2014; Keown, Holloway, & Kuipers, 2002). People with a diagnosis of BPD are associated with substantial contact with MH services (Bender et al., 2001; Zanarini, Frankenburg, Hennen, & Silk, 2004), significant functional impairment and often suicidal ideation and self-harm (NICE, 2009).

BPD is the most widely researched personality disorder diagnostic type (Blashfield & Intoccia, 2000) and has the highest prevalence in non-forensic mental health services (NICE, 2009). The term BPD is used within this review not because the author/s endorse the diagnosis, but because this term is frequently found within the literature and the meanings associated with it appear to be a key part of the problem.

The Problem

The exclusion of people with a personality disorder diagnosis from services was criticised within National Institute for Mental Health England guidance in 2003 (NIMHE, 2003). This outlined required improvements including staff training and development of specialist services in light of the growing evidence base for effectiveness of psychological interventions for BPD (Stoffers-Winterling et al., 2012). However, despite these changes, the research outlined below suggests covert exclusion persists, with continued reports of clinicians finding SUs with a BPD diagnosis challenging to work with and SUs encountering discriminatory attitudes and treatment from staff.

Many papers have demonstrated staff's negative attitudes and emotional responses towards people with a BPD diagnosis, as concluded by a review by Sansone and Sansone (2013) stating they hold more judgmental and prejudicial views about this group than those with other MH difficulties. The majority of research has focused on nursing staff, with reviews concluding this professional group often report these SUs to be more challenging than other presentations and may respond in potentially counter-therapeutic ways (Cleary et al., 2002; Dickens et al., 2016; Eastwick & Grant, 2005; Filer, 2005; Westwood & Baker, 2010). Therapists have also been found to have more negative emotional responses towards people with BPD diagnoses and report experiencing them as more withdrawn and less responsive to therapy (Bourke & Grenyer, 2010). Staff have described people with BPD diagnoses as manipulative, destructive and dangerous, and having greater ability to control their difficulties, expressing less empathy towards them than other groups (Markham, 2003; Markham & Trower, 2003; McGrath & Dowling, 2012). Lewis and Appleby (1988) found psychiatrists reported dislike for SUs with BPD diagnoses, viewing them as less deserving of care, having control over their suicidality and making negative judgements about their character and motivations; views which continue to be found in trainee psychiatrists (Chartonas, Kyratsous, Dracass, Lee, & Bhui, 2017). Sansone and Sansone (2013) proposed these negative attitudes are likely to adversely

impact care and outcomes, although Dickens et al.'s (2016) review concluded empirical evidence regarding the effect on clinical behavior is lacking.

Qualitative studies exploring service experiences of people with BPD diagnoses have highlighted that although some positive relationships with staff are described, unhelpful responses from professionals remain common (Morris, Smith & Alwin, 2014; Veysey, 2014). Despite awareness of discriminatory attitudes from staff, some SUs indicate valuing their contact with services (Fallon, 2003). Additionally, several have reported experiencing this diagnosis to create a barrier to accessing care (Stalker, Ferguson & Barclay, 2005; Veysey, 2014; Lawn & McMahon, 2015).

Existing Models

Two relevant models were identified in the literature. The first is an unpublished model of helpful service relationships for people with BPD (McGregory, 2010). This was derived from grounded theory analysis of interviews with eight staff and eight SUs and based upon attachment theory principles. It suggests that services offering a parental-like, validating and consistent approach and sharing responsibility with SUs create a 'secure' attachment with people experiencing BPD-related difficulties, and thus foster recovery. Similarly, it suggests less helpful services result in disorganised attachments with SUs and experiences of rejection, dependency and disempowerment. It advocates for drawing on attachment principles when offering this group care and suggests utilising specialist BPD models to develop a shared understanding and increase consistency. Despite providing a useful description of qualities of helpful and unhelpful service relationships, this model does not offer an explanation as to why these difficulties occur.

The second model presents a cycle used by the authors to understand staff experiences of working with people with long-standing interpersonal difficulties within a specialist BPD service (McCusker, Chambers, Allen, Woods & Bowri, 2018). They propose that the challenges and complexity of this group can lead clinicians to feel confused and overwhelmed, and subsequently deskilled, resulting in staff, teams or different services moving between overly complex and overly simple formulations of SUs problems. This offers a way for staff to recognise and reflect on these processes and encourages them to seek a more balanced understanding. However, it does not consider factors which may mediate staff's ability to do this, or SU experiences, and omits additional factors present in

non-specialist services; thus potentially risking being an overly simplistic conceptualisation itself.

Providing staff with a framework to aid understanding of possible difficulties and why they might occur has been suggested as potentially beneficial to increase their ability to recognise and make sense of these, and thus reduce the likelihood of unhelpful relational patterns occurring (Stroud & Parsons, 2013; Moore, 2012). This paper presents a framework which attempts to overcome the limitations of these existing models by offering possible explanations for these relational difficulties and considering potentially influential factors which may be particularly pertinent to dynamics outside of specialist services. This conceptual review proposes that a key part of the problem is the way unhelpful service reactions tend to parallel SUs core difficulties and unhelpful coping. It considers factors introduced by SUs and those present at various levels of the service that may contribute to or maintain counter-therapeutic systemic reactions.

Service Repetition and Mirroring of Core Processes Related to BPD

Interpersonal difficulties are part of the BPD diagnostic criteria (APA., 2013). Higher emotional reactivity to relational stressors was found within this group by a systematic review of experimental studies (Lazarus, Cheavens, Festa, & Rosenthal, 2014), and thus likely to be present in therapeutic relationships. Drawing on psychological theories underpinning evidence-based interventions for BPD, core processes relevant to the problems associated with this diagnosis are considered in the context of relationships with care providers.

Repeating Early Patterns of Care Within Services

Various psychological theories and associated therapeutic approaches propose that current unhelpful relational patterns are echoes of past relationships with early caregivers. Empirical evidence for the association between insecure attachment and the diagnosis of BPD is strong (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004; Levy, 2005), suggesting this group are less likely to have experienced repeated good-enough care in childhood ranging from mis-attuned to neglectful or abusive. These early relationships form internal working models of self and others (Bowlby, 1988) which shape our expectations of how others will behave towards us (Danquah & Berry, 2013).

Therefore, people with BPD diagnoses are likely to have difficulties feeling secure within adult relationships, particularly when seeking help. Systematic reviews have concluded insecure attachment is consistently associated with poorer working alliances (Bernecker, Levy & Ellison, 2014), particularly when SU rated (Diener & Monroe, 2011; Smith, Msetfi & Golding, 2010). Similarly, early maladaptive schemas are proposed to develop when basic needs were not met in childhood, and when triggered in adulthood can result in negative affect and self-defeating coping responses, for example attempts to avoid feared responses from others such as rejection or abandonment (Jacob & Arntz, 2013). Interpersonally, people are therefore likely to unconsciously relate in ways which may prompt others to respond negatively, inadvertently reinforcing the schema (Young, Klosko & Weishaar, 2003). As captured by McGregory (2010), characteristics of this insecure attachment style (such as inconsistent responding) may be mirrored by services and perpetuate the problem.

Other strategies to manage these threats are proposed by psychodynamic theory, for example transference, projective identification and splitting of self and others (Shapiro, 1978). Some correlational evidence suggests these defences may be more common in BPD than the general population (Kramer, Roten, Perry, & Despland, 2013). Nurses have reported SUs with BPD diagnoses moving between idolising and demonising staff and view some clinicians as all good and others as all bad, perceived by some staff as attempts to 'split' the team (Woollaston & Hixenbaugh, 2008). This may be mirrored by opposing views about the SU within the team in response. Negative countertransference has been found to predict poorer working alliance (Ligiéro & Gelso, 2002) suggesting these processes may negatively impact care relationships. The diagnosis of BPD has been experienced by some SUs as a rejection by services (Horn, Johnstone, & Brooke, 2007). Drawing on cognitive analytic theory (Ryle, 2004), people may consequently be rejecting and challenging of services attempting to protect themselves from this perceived rejection, thus unintentionally reinforcing staff's perception of them as difficult.

Schema theory proposes people have different emotional modes (Young et al., 2003). Higher use of maladaptive modes and lower use of 'healthy adult' mode by people with BPD comparative to controls was found in a small experimental study (Arntz, Klokman & Sieswerda, 2005). People with BPD-related difficulties are hypothesised to 'flip' between modes more readily and intensely than other groups, as demonstrated within an

experimental study inducing interpersonal stress (Sempértegui, Karreman, Arntz & Bekker, 2013). Staff may struggle to comprehend people's changeable presentation and employ strategies to manage this, such as holding overly simplistic explanations (for example, they are bad or manipulative) as expressed in McGrath and Dowling (2012). This is in line with McCusker et al's (2018) proposal that staff may switch between excessively complicated and simple formulations in the face of complexity which feels overwhelming, however empirical evidence for this hypothesis is lacking.

Staff also have internal working models for relationships which may influence their interactions with SUs. A cross-sectional questionnaire study of 249 NHS staff found different maladaptive schemas were present for staff dependent on profession, which related to the tasks involved (Bamber & McMahon, 2008). The authors concluded this supports Bamber's (2006) schema-based occupational stress model which hypothesises people are drawn towards professions affording them opportunities to reenact and attempt to work through their maladaptive schemas. They also found significant associations between maladaptive schemas and occupational stress and signs of burnout, including depersonalisation, emotional exhaustion and personal accomplishment (Bamber & McMahon, 2008), suggesting these may impact on SU care. Preliminary evidence suggests clinician's attachment style may affect their therapeutic interactions and outcomes (Degnan, Seymour-Hyde, Harris & Berry, 2016; Sauer, Lopez & Gormley, 2003). One study found staff with insecure attachments were more likely to reactively respond to SUs attachment styles in ways which may reinforce these unhelpful models of relationships (Dozier, Cue & Barnett, 1994).

Service Mirroring of Mentalising Difficulties

Mentalisation is the ability to make sense of our own and others behaviour in terms of internal mental states (also referred to as reflective functioning). Understanding behaviour as arising from intentions, emotions and desires informs how people make sense of their social worlds (Bateman & Fonagy, 2016). Drawing on attachment theory, this capacity is proposed to develop through our own mental states being understood by sufficiently attuned caregivers as infants (Fonagy, Target, Gergely, Allen, & Bateman, 2003; Fonagy & Bateman, 2007). Significant associations between reflective functioning capacity and personality functioning have been found in BPD samples (Antonsen, Johansen, Rø, Kvarstein, & Wilberg, 2016; Fischer-Kern et al., 2010).

Mentalisation theory posits that people may struggle to think about the thoughts of others when highly distressed, particularly those with less experience of having this distress understood and tolerated by others at early stages of development, as is common in BPD (Bateman & Fonagy, 2010). When applied to adult interpersonal relationships, this underdeveloped ability means people may then struggle to take other's perspectives and make sense of their intentions. This is proposed to be most likely to occur when the attachment system is activated (Fonagy & Bateman, 2008). In relationships with professionals in care settings, this may mean SU's are less able to consider the reasons behind staff or services responses to them. Staff may mirror this by struggling to reflect on the intentions underlying behaviours of people diagnosed with BPD or their reactions to staff's attempts to provide care. For example, staff report viewing SUs behaviours which are likely to be attempts to get their needs met or expressions of distress as manipulative (Treloar, 2009).

Developing an increased capacity to mentalise is suggested as the mechanism for change in Mentalisation-Based Therapy (Bateman & Fonagy, 2010). This is proposed to occur via the therapeutic relationship, with the therapists' ability to mentalise about SUs being key (Fonagy & Bateman, 2008). Analysis of transcripts of 20 psychologists discussing therapy processes noted they used significantly more words associated with negative emotions, self-reference and adverbs when discussing their work with SUs with a BPD diagnosis compared to those with depression (Bourke & Grenyer, 2017). They also used significantly less words associated with causation and cognitive processes (such as understand and think). The authors conclude this increased self-focus and negative emotional expression is likely to parallel difficulties in therapy sessions and connote the challenges for therapists maintaining mentalising when working with the complexity associated with BPD (Bourke & Grenyer, 2017). One small correlational study reported therapists' reflective functioning as a significant predictor of therapeutic outcomes (Cologon, Schweitzer, King, & Nolte, 2017).

Mentalizing has been shown to reduce when experiencing stress (Nolte et al., 2013), therefore staff may be more likely to struggle to mentalise about SUs when faced with risk or threat, or if experiencing pressure from the service (such as increased caseloads or a culture of criticism or defensiveness). Staff's experience of pressure from

services could be conceptualised as the service also failing to mentalise about the staff by not being adequately attuned to their emotions (e.g. stress) or intentions (e.g. doing the best they can).

Service Mirroring of the Struggle to Tolerate Strong Emotions and Associated Risk

BPD is often associated with self-harm and risk of suicide (NICE, 2009). Up to three-quarters of people with this diagnosis attempt to end their life at least once and approximately 10% complete suicide (Black, Blum, Pfohl, & Hale, 2004). Risk behaviours have been conceptualised as an 'unskilful' way of reacting to strong emotions which are poorly understood and feel unbearable (Linehan, 1993). Linehan's (1993) model (underpinning Dialectical Behaviour Therapy) describes how individuals with a BPD diagnosis may react impulsively to difficult emotions in attempts to change their emotional state, potentially creating a state of 'unrelenting crisis' due to the consequences of these actions triggering further unbearable feelings.

Systematic reviews have concluded staff attitudes towards SUs who self-harm are often negative (Saunders, Hawton, Fortune & Farrell, 2012) and SUs report experiencing poor responses and care from services (Taylor, Fortune, Hawton & Kapur, 2009), both linked to level of perceived staff knowledge. Attempting to support someone reacting in repeated high-risk ways can be anxiety provoking for staff, especially without sufficient support (Aviram, Brodsky, & Stanley, 2006). As suggested by Smith, Bouch, Bradstreet, Lakey, Nightingale and O'Connor (2015), staff may then mirror the SUs difficulties tolerating these strong emotions and react impulsively in attempts to cope with these feelings (e.g. becoming over or under involved or jumping between care strategies), inadvertently contributing to the crisis. Working with people at high risk of self-harm or suicide is associated with high levels of staff stress, as reported by DBT clinicians (Perseius, Kåver, Ekdahl, Åsberg, & Samuelsson, 2007). Nurses have described working with self-harm like 'being burdened with feelings' (Wilstrand, Lindgren, Gilje, & Olofsson, 2007). They reported incidents of this fear and frustration overwhelming them and shouting at SUs or coping by emotionally distancing themselves; responses which were more likely when team or management support felt lacking (Wilstrand et al., 2007). These non-empathetic staff responses to protect themselves are likely to impact SUs, demonstrated by reports that negative responses from staff intensified their distress (Morris et al., 2014). SUs have described solely focusing on risk reduction as less helpful than exploring

underlying distress (Morris et al., 2014), in line with a review by Koekkoek, Hutschemaekers, van Meijel and Schene (2011) suggesting largely taking a risk-focused approach may foster dependence.

The often-elevated risk in this group may also interact with individual staff characteristics, for example their own fear of death. A correlational questionnaire study of 120 psychiatrists found their fear of death was significantly associated with higher negative emotions towards SUs diagnosed with BPD (Bodner, Shrira, Hermesh, Ben-Ezra, & Iancu, 2015), which remained after controlling for experience with this group and views about suicide. The authors posit professionals feeling unable to compensate for their own high death anxiety by successfully treating people diagnosed with BPD may result in negative emotional responses to this group (Bodner et al., 2015).

Risk assessment has been discussed as inherently anxiety-provoking and Undrill (2007) proposes management of institutional anxiety around risk is key for staff to be able to contain patient anxiety. Consequently, a perceived culture of blame within services may heightened the sense of threat and lead to unhelpful defensive practice (Undrill, 2007). In one small study, 85% mental health staff disclosed having made clinical decisions against SUs best interests to protect themselves from possible repercussions (Krawitz & Batcheler, 2006), which they attributed to concerns about both service-level and society-level responses.

There are mixed views within the literature regarding merit of inpatient treatment for this group (Paris, 2004; Bateman & Tyrer, 2004). NICE guidelines (2009) conclude there is a lack of evidence about the impact of admissions, making informed decisions around admissions difficult. Some express concerns regarding negative longer-term consequences, such as reinforcing dependency on services, expressing risk becoming associated with increased care, and improvements with abandonment by services (Paris, 2004). However, without robust community alternatives people with this diagnosis are likely to continue to seek hospital care and re-experience a sense of rejection as services may attempt to avoid admissions due to fears they are counter-therapeutic. This is reflected in qualitative studies of people with BPD diagnoses experiences of inpatient care, reporting being refused admission (Horn et al., 2007; Stalker et al, 2005) or repeated cycles of short admissions and discharge due to their diagnosis (Rogers & Dunne, 2011).

Brief admissions collaboratively included within a care plan have been cited as helpful for some, although dependent on inpatient staff responsiveness (Helleman, Goossens, Kaasenbrood & Achterberg, 2014), which others indicate is negatively impacted by their BPD label (Rogers & Dunne, 2011).

Staff and Service-Level Contributions to Systemic Challenges of Working with People with a BPD Diagnosis

Stigma Associated with Borderline Personality Disorder

Mental health diagnoses have been linked with negative stigma (Corrigan & Watson, 2002), which is associated with reduced help-seeking (Clement et al., 2015). The public have been found to express less sympathy towards difficulties associated with BPD than other mental health problems (Furnham, Lee & Kolzeev, 2015), reflecting previously discussed attitudes found in staff (Dickens et al., 2016; Sansone & Sansone, 2013). In an experimental study, staff reported fewer reasons to be optimistic and anticipated more difficulties working with the person when primed with the label BPD than when presented with the same clinical information without a diagnosis (Lam, Poplavskaya, Salkovskis, Hogg, & Panting, 2016). This suggests staff may hold stigmatising attitudes in association with the BPD label itself, rather than the associated difficulties. A critique of this study is that the questionnaire used may capture appropriate adjustments to therapy length expectations in light of potential complex trauma and additional time needed to build therapeutic relationships, rather than unwillingness to engage with this group, thus replication with more nuanced measures may be beneficial.

The stigma associated with mental health problems can lead to social distancing to manage existential anxiety around our own vulnerabilities (Baumann, 2007). Evidence suggests people with BPD diagnoses may have particular sensitivity to rejection (Rosenbach & Renneberg, 2014). Accordingly, this may lead to negative reactions such as withdrawal from services, more extreme attempts to receive care, or anger, behaviours which potentially reinforce the stigma associated with BPD (Aviram et al., 2006).

According to labelling theory (Link, Cullen, Frank, & Wozniak, 1987), mental health diagnoses may influence people to behave in line with their given label. Qualitative research reported SUs felt defined by their BPD diagnosis and perceived staff to

subsequently interpret their difficulties and behaviours purely in relation to BPD (Morris et al., 2014). Awareness of a BPD diagnosis may lead clinicians to make assumptions about the presence of behaviours or difficulties associated with this (such as self-harm or dependency) which may not be relevant for that specific person considering BPD's heterogenous nature (APA, 2013). Holding expectations of how someone might behave is likely to impact on how you relate to them, and subsequently their responses to you, potentially creating a self-fulfilling prophecy.

Attribution theory proposes humans are predisposed to seek causal explanations for events, which then influence our emotional and behavioural responses (Weiner, 1985). Viewing behaviours as controllable may lead to anger or loss of empathy and result in withdrawal of care or punishment. This is consistent with reports of nurses viewing behaviours of people diagnosed with BPD as comparably more within their control, expressing less empathy and more anger towards them (Forsyth, 2007; Markham & Trower, 2003). A mixed-methods study and review suggested clinicians attributing behaviour to poor coping skills or personality traits and thus as controllable often leads to ambivalence about the SU and their responsibility for treatment (Koekkoek, van Meijel, & Hutschemaekers, 2006). They propose this may lead to a cycle of ineffective SU and staff behaviours, and SUs being labelled as 'difficult' and thus rejected (Koekkoek et al., 2006). Similarly, previous negative experiences with services could understandably mean SUs are less engaged when next interacting with mental health professionals, which may be viewed as further evidence of 'difficult' behaviour and interpersonal difficulties, providing further support for BPD diagnosis and associated negative staff attitudes.

The diagnostic criteria for BPD are a description of behaviours, however they are sometimes interpreted as explanatory and indicative of cause. Stalker et al. (2005) found some SUs thought personality disorder meant there was something inherently wrong with them as a person and viewed it as a pejorative term. SUs report not always being told their diagnosis and finding out inadvertently, which some interpreted to mean it is something bad to be hidden (Ociskova et al., 2017). This is reflected in psychiatrist survey responses finding 57% had not disclosed a BPD diagnosis to a SU due to uncertainty or concerns about stigma (Sisti, Segal, Siegel, Johnson & Gunderson, 2016). Lack of diagnosis disclosure was suggested by a systematic review to impact on collaborative decision

making, foster distrust and damage relationships with services (Perkins et al., 2018), and thus potentially perpetuate marginalisation (Kealy & Ogrodniczuk, 2010).

Systemic Challenges to Maintaining Therapeutic Optimism

As individuals with a diagnosis of BPD were previously viewed as “untreatable” (NIMHE, 2003), outdated pessimism regarding recovery may contribute to this dynamic. This position is no longer justified considering a Cochrane review concluded clear benefits of psychotherapy for BPD, including DBT, MBT, TFT, SFT and STEPPS (Stoffers-Winterling et al., 2012). They reported the most robust evidence for effectiveness exists for DBT and concluded disorder-specific psychotherapy is warranted as the first-line treatment for BPD, although a meta-analysis suggested effect sizes are small (Cristea et al., 2017). Ideas regarding chronicity of these difficulties now also appear untenable considering emerging evidence for remission. A longitudinal study reported 75% of originally interviewed inpatients diagnosed with BPD no longer met diagnostic criteria over the six-year study, with a steady progression of remission rates over two, four- and six-years (Zanarini, Frankenburg, Hennen, & Silk, 2003). The authors state this indicates symptomatic prognosis is more promising than previously assumed.

Despite these advancements, staff continue to view this group less optimistically (Lam et al., 2016). Evidence suggests longer-term interventions are needed (NICE, 2009) and medication has limited utility (Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010). Therefore change is likely to be more gradual and over a longer time-period than other difficulties such as depression or anxiety, meaning staff and SUs may receive less short-term reinforcement for their efforts. If staff are not optimistic about potential benefits from intervention, this may impact on outcomes. Attribution theory proposes interpretations of unchangeability result in hopelessness and decreased helping (Weiner, 1985), meaning staff may reduce their helping efforts if they perceive these to be futile. Some small studies support the relationship between therapist hope and outcomes (Coppock, Owen, Zagarskas, & Schmidt, 2010), potentially mediated by therapeutic alliance (Ardito & Rabellino, 2011). SUs with this diagnosis may also feel unhelpable, particularly if staff do not convey hope about recovery, possibly impacting on treatment efficacy considering SU expectations have been found to impact therapy outcomes (Greenberg, Constantino, & Bruce, 2006). Notably, more severe difficulties and stronger therapeutic alliance predict positive therapy outcomes for people diagnosed with BPD (Barnicot et al., 2012). This

demonstrates the importance and validity of conveying therapeutic optimistic for people with this diagnosis who are most distressed.

Little is known about clinicians' perceptions of recovery in BPD (Ng, Bourke & Greyner, 2016). One small opportunistic Q-sort study identified two perspectives held by staff; one focusing on reduction of symptoms as key and another on factors relating to general wellbeing; these opposing views may threaten consistent team-working (Dean, Siddiqui, Beesley, Fox & Berry, 2018). A meta-synthesis of fourteen qualitative studies exploring SU's perspectives of BPD treatment and recovery identified nature of change as a key domain, with SUs referring to recovery as a continuous process of improvements and difficulties (Katsakou & Pistrang, 2018). Instilling hope, focusing on change and collaborative, respectful relationships were highlighted as important for recovery, in addition to improvements such as increased emotion regulation. An additional qualitative study echoed the fluctuating nature of recovery, and further reported SUs did not identify with recovery as a return to prior functioning (McCusker, Turner, Pike & Startup, 2018). They reported service's focus on symptom reduction did not fit with their priorities or experiences of recovery, fostering hopelessness and feelings of being misunderstood (McCusker et al., 2018). Considering these factors, and as services are most likely to have contact with SUs with BPD diagnoses during crisis, recovery narratives may be less readily available for staff and subsequently communicated to SUs.

Service Mis-Attunement with Needs of People with a BPD Diagnosis

Evidence suggests the medical model provides inadequate explanations of this groups difficulties and ways to intervene. A Cochrane review (Lieb et al., 2010) concluded existing RCT outcomes do not support medication effectiveness for overall severity in BPD. One meta-analysis found no helpful effects from medication for BPD aside from some indications anti-psychotics and mood stabilisers may have some benefits for specific symptoms within this population, although evidence was of poor quality (Olabi & Hall, 2010). The NICE (2015) quality standard for personality disorder reflects this, stating there are no medications with established efficacy for BPD and therefore pharmacological interventions should only be utilised for short-term crisis management or comorbid disorders. However a large scale survey of prescribing rates for people with BPD diagnoses across UK NHS mental health services found 92% were prescribed psychotropic medication, contrary to NICE recommendations and often outside of licensing

(Paton, Crawford, Bhatti, Patel, & Barnes, 2015). Rates and type of medication were similar regardless of co-morbid disorders, and, concerningly, rates of review within the last year were lower for those with only a BPD diagnosis (Paton et al., 2015).

The increased risk of self-harm or suicide associated with this group (Black et al., 2004) may create an urgency for treatment. Combined with the conflict of recommendations that medication can be used for crisis when crisis can be frequent (NICE, 2009), this likely leads to difficulties judging appropriate prescribing (Starcevic & Janca, 2018). In a qualitative study exploring experiences of medication use for BPD, SUs reported awareness of staff's limited knowledge and understanding of BPD and appropriate interventions, and of limited service resourcing for BPD. They felt this resulted in staff focusing on medication as the primary treatment approach or offering no intervention, although this improved when specialist services were available and they valued involvement in decision-making about medication use (Rogers & Acton, 2012).

Sulzer, Jackson & Yang (2016) referred to this "biomedical mis-match" between care services and the difficulties associated with BPD. They derived from clinician interviews that the misalignment of taking a medical approach due to training or service provision when evidence suggests long-term psychotherapeutic interventions are most effective may lead to crisis management and a narrative of this group being untreatable (Sulzer et al., 2016). Subsequently, over-reliance on a medical approach to BPD treatment which has little evidence for effectiveness may lead to feelings of frustration or incompetence for staff (Treloar, 2009), potentially influencing clinical behaviour.

Despite guidelines advocating for specialist personality disorder services (DOH, 2009; NIMHE, 2003), access and funding for these is not mandated and monitored in the way some services for other mental health difficulties are (such as Early Intervention for Psychosis services; NICE, 2006). In a recent survey, 84% of England NHS Trusts reported offering at least one specialist PD service, a five-fold improvement since 2002 (NIMHE, 2003), however only 55% reported equal access across localities, concluding variability of availability remains common and quality of care unclear (Dale et al, 2017).

Staff Training and Experience

Social distancing and staff negative attitudes are proposed to be driven by a lack of understanding about BPD (Westwood & Baker, 2010). A recent systematic review of multi-disciplinary staff (Attwood, 2018) concluded training to improve staff attitudes towards individuals with a diagnosis of BPD appears effective, with changes maintained after six months, although effect sizes were small. The inclusion of a psychological model, clinical skills and lived experience co-facilitator improved effectiveness (Attwood, 2018). These findings imply that providing a framework to understand difficulties and tools to intervene may help modify unhelpful beliefs regarding control of difficulties and treatability, and exposure to people who have recovered following a BPD diagnosis may increase optimism. However, although research in other areas has reported associations between attitudes and behaviours (Glasman & Albarracin, 2006), the influence of attitude changes following training on subsequent behaviour has not been empirically demonstrated within mental health staff (Attwood, 2018). The proposed role of positive contact with people diagnosed with BPD in potentially reducing stigma is consistent with a review concluding contact was more effective than educational training (Corrigan & Fong, 2014).

There is some support for improvements in staff attitudes following skills training in specific psychotherapeutic approaches relevant to BPD. Training mental health nurses to deliver DBT interventions (Linehan, 1998) has led to some attitudinal improvements, although existing research is limited and lacking methodological rigour (Dickens et al., 2016). Reported attitude shifts pre-post training include moving from therapeutic pessimism to increased hope for recovery and confidence in skills to assist change (Hazelton, Rossiter & Milner, 2006). DBT training has also been found to mitigate the stress of working with self-harm (Perseius et al., 2007). STEPPS and MBT skills training also show promise in improving staff knowledge and attitudes towards people with BPD diagnoses (Polnay, MacLean, Lewington, & Patrick, 2015; Shanks, Pfohl, Blum & Black, 2011; Welstead et al., 2018). Following a two-day MBT-skills training, inpatient nurses reported increased empathy and understanding towards this group, more optimism and ability to tolerate risk, and consistent responding within the team (Warrender, 2015). Specific training in BPD and experience with this group are reportedly associated with reduced likelihood of harmful responses to self-harm (Commons Treloar & Lewis, 2009).

Supervision and Burnout

Greater distress and need for supervision when working with people with a BPD diagnosis comparative to other difficulties has been reported by therapists (Bourke & Greyner, 2013). Working with SUs with a PD diagnosis who are highly distressed is reportedly associated with increased staff stress (Montgomery, Lloyd & Holmes, 2000), and higher risk of burnout (Chandler, Newman & Butler, 2017). Supervision is a key element in various therapeutic approaches for BPD (Linehan, 1993; Bateman & Fonagy, 2016), and ensuring supervision provision recommended for staff working with this group (NIHME, 2003). Evidence suggests supervision may enhance clinician's self-awareness in SU interactions, increase skills, provide emotional support and reduce risk of burnout (Edwards et al, 2006; Wheeler & Richards, 2007). These benefits may be particularly needed for effective working the interpersonal difficulties associated with this group (Moore, 2012).

A meta-analysis found high levels of emotional exhaustion and moderate depersonalisation in mental health staff, and suggested community mental health work may have higher burnout risks than specialist services (O'Connor, Neff & Pittman, 2018). Emotional exhaustion and depersonalisation in healthcare professionals have been associated with 'stress of conscience' from feeling unable to deliver the care needed (Glasberg, Eriksson & Norberg, 2007). This may be pertinent considering earlier described evidence that staff may feel under-skilled or resourced to provide care for people with BPD. Organisational pressures, high workloads and lack of resources have been connected with burnout (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000), which in turn has been associated with rejecting feelings towards SUs (Holmqvist & Jeanneau, 2006) and reduced empathy (Wilkinson, Whittington, Perry & Eames, 2017). Lower burnout and higher personal accomplishment has been reported in specialist PD services compared to generic mental health services, with reflective practice and cohesive, consistent team-working and leadership considered protective (Crawford, Adedeji, Price & Rutter, 2010). The authors posit this suggests if services can provide containment and support then working with BPD does not necessarily have a negative impact on staff.

Proposed Model and Implications

Synthesising themes from the literature reviewed above, the proposed model (Figure 1.1) is presented below with two main interacting components: mirroring of interpersonal processes associated with BPD and contributing staff and service-related factors.

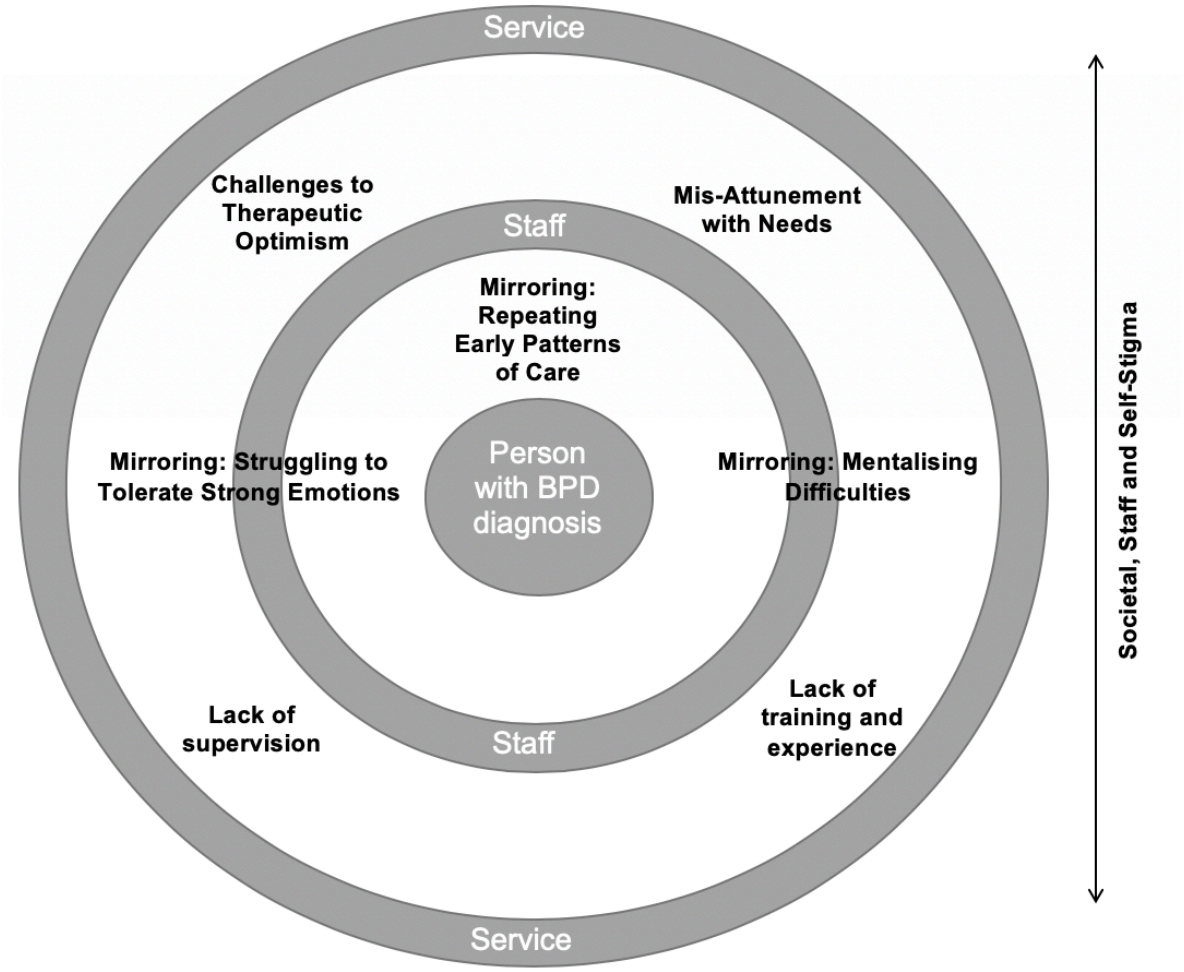

Figure 1.1: Tentatively proposed theoretical model of interpersonal and systemic factors which may contribute to unhelpful relationships between people diagnosed with borderline personality disorder and mental health services

Although there is variation in how BPD specific models conceptualise the core interpersonal difficulties, there are many similarities in how they highlight the impact of early experiences on later relationships. The ideas and evidence reviewed within this paper suggest that for effective therapeutic working with individuals with BPD diagnoses,

staff need training in an explanatory model and supervision and reflective space to apply this and recognise unhelpful staff/service reactions which may mirror the person's difficulties. When faced with complexity and risk, staff may mirror SUs difficulties in mentalising about the thoughts and intentions underlying people's potentially changeable or challenging behavior, and in tolerating the distress often experienced by this group, leading them to respond in ways which perpetuate these difficulties. Staff who hold stigmatising attitudes towards people with a diagnosis of BPD, such as viewing them as more difficult to work with than other SUs, may experience a sense of threat when working with this group. This threat response may also be increased by the higher level of risk often associated with BPD, particularly within services where staff perceive there to be a culture of blame and individual responsibility for risk. This perceived threat may result in a fight or flight response. Negative staff responses to people with a diagnosis of BPD may be conceptualized in this way; for example, blaming them for their difficulties, negatively judging them or responding in unhelpful or even abusive ways may be interpreted as fight responses, and rejecting, avoiding, withdrawing or not providing care for this group as flight responses. Applying ideas from compassion focused therapy (Gilbert, 2010) may therefore be of value for MH staff, aiming to reduce activation of the threat system in response to working with people with a BPD diagnosis and increase their ability to access their soothing system. Interventions focused on increasing compassion both for self and others may help reduce unhelpful responses to SUs with BPD diagnoses.

Despite the interpersonal nature of the core difficulties being established and repeated patterns of care present in psychological models of BPD, there is limited research regarding this. The occurrence of negative staff attitudes towards this group have been consistently demonstrated. However, further research is needed to elucidate the impact of these on clinical practice which is suggested by SU accounts of discriminatory and poor treatment (Dickens et al, 2016). Adequate provision of specialist services and time for teams to think together to encourage consistent, considered responding rather than reactive management appears key. Further research regarding medication use for crises and effectiveness and long-term consequences of inpatient care for this group would be beneficial to inform decision-making and risk management. Admissions may potentially be more helpful if brief and part of collaborative, planned care rather than reactive and including people in decisions about their care is likely to be beneficial for therapeutic relationships.

Training in psychotherapeutic models of BPD shows promise for improving attitudes and increasing skills, confidence and optimism in working with this group. To instill justified therapeutic optimism and reduce stigma, contact with people with BPD diagnoses who are in recovery may be particularly helpful. Time and resources (such as supervision and reflective practice) appear important to allow staff space to develop awareness of when they might be caught up in these dynamics, including awareness of the proposed model to frame thinking. The BPD label continues to be associated with negative attitudes and experiences, calling into question it's continued use on balance of harm and value, however others argue this group may continue to be viewed as 'difficult' but under a different name (Paris, 2005).

Considering the interpersonal difficulties brought by the SU and the context of various systemic challenges, it is perhaps understandable that professional care relationships with this group often create strong emotional responses and subsequently the risk of unhelpful relating. However, it also suggests that people with these difficulties particularly need of attuned, reflective care, as their difficulties often relate to struggling to provide this for themselves due to lack of experiences of this during childhood (Bateman & Fonagy, 2016). In turn, staff providing this are perhaps also particularly in need of consistency, resourcing, and containment and understanding from services to be able to deliver care and maintain a helpful relational stance. This model suggests techniques used with SUs in psychological therapies for BPD may be helpful if applied to services. As concluded by a systematic review regarding attachment-informed mental health care, the system needs to model secure attachment by providing both support and dependability but also allowing flexibility locally to enable staff to successfully offer this to SUs (Bucci, Roberts, Danquah & Berry, 2014).

Strengths and weaknesses of evidence informing proposed model

Evidence for negative staff attitudes towards this population is established using systematic review methodology (e.g. Cleary et al., 2002; Dickens et al., 2016; Eastwick & Grant, 2005; Filer, 2005; Westwood & Baker, 2010). However, although the theoretical underpinnings pertinent to the various factors outlined above are discussed, empirical evidence to support many of these proposed ideas is currently lacking or highly limited in scope and rigour. Many of the included studies, particularly pertaining to SU experiences,

did not contain a comparison clinical group and therefore it is not clear to what extent difficult relationships with services is specific to BPD (although this distinction is more established within the staff literature). This review also draws on many studies which used qualitative methodologies, an approach which provides an in-depth insight and understanding of people's experiences but is limited in generalisability and potentially impacted by the researcher's interpretations (depending on the epistemological position taken) when their stance and pre-existing ideas are not disclosed or considered. The few small-scale studies included which used quantitative outcome measures (for example, investigating impact of staff training interventions) were mainly uncontrolled and opportunistic, potentially introducing risk of bias in participant sampling and demand characteristics, and meaning findings may not be applicable outside that service. Training invention studies also often did not include follow-up data, as highlighted by Attwood (2018). However, many of the included studies were concluded within everyday healthcare settings, which increases the ecological validity of their findings. Much of the included existing research is correlational and thus causation cannot be inferred and is not established. In light of this limited evidence, the model and it's hypotheses are tentatively proposed. Therefore, further research is required to test these, ideally using quantitative methodology with controlled designs, clinical comparison groups and measures with established psychometric properties. For example, measuring staff's perceived ability to tolerate distress using the distress tolerance scale (Simons & Gaher, 2005) during or immediately after therapeutic interactions with people with a BPD diagnosis comparative to after interactions with another clinical group.

Limitations

Due to the research questions' breath presenting all relevant research was not feasible, therefore papers were chosen selectively to illustrate how the factors described may relate to the problem. Consequently, the inclusion and presentation of papers was likely influenced by the author's position and pre-training experience of these dynamics in inpatient and specialist community services for people with BPD diagnoses. Additionally, a thorough critique of the quality of research was unfeasible as studies were collated from a range of topics using various methodologies, restricting direct comparison.

Conclusions

This is the first paper to attempt to look at the systemic treatment dynamics around people with a diagnosis of BPD, recognising those introduced by the individual (often understood as a coping response to adverse childhood experiences) which may then be mirrored by staff, and those introduced by the mental health system. This unhelpful mirroring by services of early patterns of relating, and difficulties mentalising and tolerating strong emotions may be more likely when factors within the system are present, such as lack of staff training, supervision, mis-attunement of service provision to needs of people with a BPD diagnosis and therapeutic pessimism.

It is important to note that many of the factors proposed to contribute to difficult relationships between SU's and staff are not within the power of the SU to change. This model suggests that staff may have more power than SUs to positively influence these dynamics, and in turn services more influence than staff. It is hoped this model will aid understanding of why dynamics between SUs with a BPD diagnosis and services are often difficult and increase staff's ability to recognise and make sense of these, potentially reducing the problem.

References

Agrawal, H. R., Gunderson, J., Holmes, B. M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review. *Harvard review of psychiatry*, *12*(2), 94-104.

Antonsen, B. T., Johansen, M. S., Rø, F. G., Kvarstein, E. H., & Wilberg, T. (2016). Is reflective functioning associated with clinical symptoms and long-term course in patients with personality disorders? *Comprehensive Psychiatry, 64*, 46-58.

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (Fifth ed.). Washington: American Psychiatric Association.

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in psychology, 2*, 270.

Arntz, A., Klokman, J., & Sieswerda, S. (2005). An experimental test of the schema mode model of borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, *36*(3), 226-239.

Attwood, J. (2018). *Effectiveness of training aimed at improving health and social care professionals' attitudes towards people with a diagnosis of personality disorder: a systematic review* (Unpublished doctoral thesis). University of Bath, Bath.

Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry, 14*(5), 249-256. doi:10.1080/10673220600975121.

Bamber, M. (2006). Conceptualizing and treating a case of workaholism and burnout using the schema-focused approach. *CBT for occupational stress in health professionals: introducing a schema-focused approach. New York: Routledge/Taylor & Francis Group*, 191-202.

Bamber, M., & McMahon, R. (2008). Danger—Early maladaptive schemas at work!: The role of early maladaptive schemas in career choice and the development of occupational stress in health workers. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *15*(2), 96-112.

Barnicot, K., Katsakou, C., Bhatti, N., Savill, M., Fearns, N., & Priebe, S. (2012). Factors predicting the outcome of psychotherapy for borderline personality disorder: a systematic review. *Clinical Psychology Review, 32*(5), 400-412.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry, 9*(1), 11-15. doi:10.1002/j.2051-5545.2010.tb00255.x

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*: Oxford University Press.

Bateman, A. W., & Tyrer, P. (2004). Services for personality disorder: organisation for inclusion. *Advances in psychiatric treatment*, *10*(6), 425-433.

Baumann, A. E. (2007). Stigmatization, social distance and exclusion because of mental illness: the individual with mental illness as a 'stranger'. *International review of psychiatry*, *19*(2), 131-135.

Beckwith, H., Moran, P. F., & Reilly, J. (2014). Personality disorder prevalence in psychiatric outpatients: a systematic literature review. *Personality and mental health, 8*(2), 91-101.

Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H., . . . Gunderson, J. G. (2001). Treatment utilization by patients with personality disorders. *American Journal of psychiatry, 158*(2), 295-302.

Berger, B. (2014). *Power, selfhood, and identity: A feminist critique of borderline personality disorder*.

Bernecker, S. L., Levy, K. N., & Ellison, W. D. (2014). A meta-analysis of the relation between patient adult attachment style and the working alliance. *Psychotherapy Research*, *24*(1), 12-24.

Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal behavior in borderline personality disorder: prevalence, risk factors, prediction, and prevention. *Journal of personality disorders, 18*(3: Special issue), 226-239.

Black, D. W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C. S., . . . Zimmerman, M. (2011). Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians. *CNS Spectrums, 16*(3), 67-74. doi:10.1017/S109285291200020X

Blashfield, R. K., & Intoccia, V. (2000). Growth of the literature on the topic of personality disorders. *American Journal of Psychiatry, 157*(3), 472-473.

Bodner, E., Shrira, A., Hermesh, H., Ben-Ezra, M., & Iancu, I. (2015). Psychiatrists′ fear of death is associated with negative emotions toward borderline personality disorder patients. *Psychiatry research, 228*(3), 963-965.

Bouchard, M.-A., Target, M., Lecours, S., Fonagy, P., Tremblay, L.-M., Schachter, A., & Stein, H. (2008). Mentalization in adult attachment narratives: Reflective functioning, mental states, and affect elaboration compared. *Psychoanalytic Psychology, 25*(1), 47.

Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research, 20*(6), 680-691.

Bourke, M. E., & Grenyer, B. F. (2013). Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder. *Journal of personality disorders*, *27*(6), 735-745.

Bourke, M. E., & Grenyer, B. F. S. (2017). Therapists' metacognitive monitoring of the psychotherapeutic process with patients with Borderline Personality Disorder. *Journal of psychiatric practice, 23*(4), 246-253.

Bowlby, J. (1988). *Clinical applications of attachment theory. A secure base*. London, UK: Routledge.

Bucci, S., Roberts, N. H., Danquah, A. N., & Berry, K. (2015). Using attachment theory to inform the design and delivery of mental health services: A systematic review of the

literature. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(1), 1-20.

Chandler, R. J., Newman, A., & Butler, C. (2017). Burnout in clinicians working with offenders with personality disorder. *Journal of Forensic Practice*, *19*(2), 139-150.

Chartonas, D., Kyratsous, M., Dracass, S., Lee, T., & Bhui, K. (2017). Personality disorder: still the patients psychiatrists dislike? *BJPsych bulletin, 41*(1), 12-17.

Cleary, M., Siegfried, N., & Walter, G. (2002). Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing, 11*(3), 186-191. doi:10.1046/j.1440-0979.2002.00246.x.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*, *45*(1), 11-27.

Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *The British Journal of Psychiatry, 188*(5), 423-431.

Cologon, J., Schweitzer, R. D., King, R., & Nolte, T. (2017). Therapist reflective functioning, therapist attachment style and therapist effectiveness. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(5), 614-625.

Commons Treloar, A. J., & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Australian and New Zealand Journal of Psychiatry*, *42*(7), 578-584.

Coppock, T. E., Owen, J. J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. *Psychotherapy Research, 20*(6), 619-626.

Corrigan, P. W., & Fong, M. W. M. (2014). Competing perspectives on erasing the stigma of illness: What says the dodo bird? *Social Science & Medicine, 103*, 110-117.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry*, *1*(1), 16.

Crawford, M. J., Adedeji, T., Price, K., & Rutter, D. (2010). Job satisfaction and burnout among staff working in community-based personality disorder services. *International Journal of Social Psychiatry*, *56*(2), 196-206.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: a systematic review and meta-analysis. *Jama psychiatry*, *74*(4), 319-328.

Dale, O., Sethi, F., Stanton, C., Evans, S., Barnicot, K., Sedgwick, R., ... & Urquia, N. (2017). Personality disorder services in England: findings from a national survey. *BJPsych bulletin*, *41*(5), 247-253.

Danquah, A. N., & Berry, K. (Eds.). (2013). *Attachment theory in adult mental health: A guide to clinical practice*. Routledge.

Dean, R., Siddiqui, S., Beesley, F., Fox, J., & Berry, K. (2018). Staff perceptions of borderline personality disorder and recovery: AQ-sort method approach. *British Journal of Clinical Psychology*, *57*(4), 473-490.

Degnan, A., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). The role of therapist attachment in alliance and outcome: A systematic literature review. *Clinical Psychology & Psychotherapy*, *23*(1), 47-65.

Department of Health. (2009*). Recognising complexity: Commissioning guidance for personality disorder services.* DOH; London.

Dickens, G. L., Hallett, N., & Lamont, E. (2016). Interventions to improve mental health nurses' skills, attitudes, and knowledge related to people with a diagnosis of borderline personality disorder: Systematic review. *International Journal of Nursing Studies, 56*, 114-127.

Dickens, G. L., Lamont, E., & Gray, S. (2016). Mental health nurses' attitudes, behaviour, experience and knowledge regarding adults with a diagnosis of borderline personality disorder: systematic, integrative literature review. *Journal of Clinical Nursing, 25*(13-14), 1848-1875. doi:10.1111/jocn.13202.

Diener, M. J., & Monroe, J. M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review. *Psychotherapy, 48*(3), 237-248.

Dozier, M., Cue, K. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of consulting and clinical psychology*, *62*(4), 793.

Eastwick, Z., & Grant, A. (2005). The treatment of people with'borderline personality disorder': a cause for concern? *Mental Health Practice, 8*(7), 38-41.

Edens, J. F., Marcus, D. K., & Ruiz, M. A. (2008). Taxometric analyses of borderline personality features in a large-scale male and female offender sample. *Journal of Abnormal Psychology, 117*(3), 705.

Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *7*(1), 7-14.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., ... & Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of clinical nursing*, *15*(8), 1007-1015.

Fallon, P. (2003). Travelling through the system: The lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing, 10*(4), 393-400. doi:10.1046/j.1365-2850.2003.00617.x.

Forsyth, A. (2007). The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*, *14*(1), 33-40.

Filer, N. (2005). Borderline personality disorder: attitudes of mental health nurses: people with borderline personality disorder often feel they are denied the respect and care they really need. Nathan Filer examines the research on the disorder and discusses how care might be improved. *Mental Health Practice, 9*(2), 34-37.

Fischer-Kern, M., Buchheim, A., Hörz, S., Schuster, P., Doering, S., Kapusta, N. D., . . . Buchheim, P. (2010). The relationship between personality organization, reflective functioning, and psychiatric classification in borderline personality disorder. *Psychoanalytic Psychology, 27*(4), 395.

Fonagy, P., & Bateman, A. (2008). The development of borderline personality disorder—A mentalizing model. *Journal of personality disorders, 22*(1), 4-21.

Fonagy, P., & Bateman, A. W. (2007). Mentalizing and borderline personality disorder. *Journal of Mental Health, 16*(1), 83-101. doi:10.1080/09638230601182045

Fonagy, P., Target, M., Gergely, G., Allen, J. G., & Bateman, A. W. (2003). The developmental roots of borderline personality disorder in early attachment relationships: A theory and some evidence. *Psychoanalytic Inquiry, 23*(3), 412-459.

Furnham, A., Lee, V., & Kolzeev, V. (2015). Mental health literacy and borderline personality disorder (BPD): what do the public "make" of those with BPD?. *Social psychiatry and psychiatric epidemiology*, *50*(2), 317-324.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features.* Routledge.

Glasberg, A. L., Eriksson, S., & Norberg, A. (2007). Burnout and 'stress of conscience' among healthcare personnel. *Journal of advanced nursing*, *57*(4), 392-403.

Glasman, L. R., & Albarracin, D. (2006). Forming attitudes that predict future behavior: A meta-analysis of the attitude-behavior relation. *Psychological bulletin, 132*(5), 778.

Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clinical psychology review, 26*(6), 657-678.

Haigh, R. (2006). People's experiences of having a diagnosis of personality disorder. *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*, 159-177.

Hazelton, M., Rossiter, R., & Milner, J. (2006). Managing the 'unmanageable': Training staff in the use of dialectical behaviour therapy for borderline personality disorder. *Contemporary Nurse*, *21*(1), 120-130.

Helleman, M., Goossens, P. J., Kaasenbrood, A., & van Achterberg, T. (2014). Experiences of patients with borderline personality disorder with the brief admission intervention: A phenomenological study. *International journal of mental health nursing*, *23*(5), 442-450.

Holmqvist, R., & Jeanneau, M. (2006). Burnout and psychiatric staff's feelings towards patients. *Psychiatry Research*, *145*(2-3), 207-213.

Horn, N., Johnstone, L., & Brooke, S. (2007). Some service user perspectives on the diagnosis of borderline personality disorder. *Journal of mental Health, 16*(2), 255-269.

Jacob, G. A., & Arntz, A. (2013). Schema Therapy for Personality Disorders—A Review. *International Journal of Cognitive Therapy, 6*(2), 171-185. doi:10.1521/ijct.2013.6.2.171

Katsakou, C., & Pistrang, N. (2018). Clients' experiences of treatment and recovery in borderline personality disorder: A meta-synthesis of qualitative studies. *Psychotherapy Research, 28*(6), 940-957.

Kealy, D., & Ogrodniczuk, J. S. (2010). Marginalization of borderline personality disorder. *Journal of Psychiatric Practice*, *16*(3), 145-154.

Keown, P., Holloway, F., & Kuipers, E. (2002). The prevalence of personality disorders, psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. *Social Psychiatry and Psychiatric Epidemiology, 37*(5), 225-229. doi:10.1007/s00127-002-0533-z

Koekkoek, B., van Meijel, B., & Hutschemaekers, G. (2006). " Difficult patients" in mental health care: a review. *Psychiatric Services, 57*(6), 795-802.

Koekkoek, B., Hutschemaekers, G., van Meijel, B., & Schene, A. (2011). How do patients come to be seen as 'difficult'?: A mixed-methods study in community mental health care. *Social Science & Medicine*, *72*(4), 504-512.

Kramer, U., de Roten, Y., Perry, J. C., & Despland, J. N. (2013). Beyond splitting: Observer-rated defense mechanisms in borderline personality disorder. *Psychoanalytic Psychology*, *30*(1), 3.

Krawitz, R. (2004). Borderline personality disorder: attitudinal change following training. *Australian and New Zealand Journal of Psychiatry, 38*(7), 554-559. doi:10.1111/j.1440-1614.2004.01409.x

Krawitz, R., & Batcheler, M. (2006). Borderline personality disorder: a pilot survey about clinician views on defensive practice. *Australasian Psychiatry*, *14*(3), 320-322.

Lam, D. C. K., Poplavskaya, E. V., Salkovskis, P. M., Hogg, L. I., & Panting, H. (2016). An experimental investigation of the impact of personality disorder diagnosis on clinicians: Can we see past the borderline? *Behavioural and Cognitive Psychotherapy, 44*(3), 361-373. doi:10.1017/S1352465815000351

Lawn, S., & McMahon, J. (2015). Experiences of care by Australians with a diagnosis of borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 22*(7), 510-521.

Lazarus, S. A., Cheavens, J. S., Festa, F., & Rosenthal, M. Z. (2014). Interpersonal functioning in borderline personality disorder: A systematic review of behavioral and laboratory-based assessments. *Clinical psychology review*, *34*(3), 193-205.

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Dev Psychopathol, 17*(4), 959-986.

Lewis, G., & Appleby, L. (1988). Personality Disorder: the Patients Psychiatrists Dislike. *British Journal of Psychiatry, 153*(1), 44-49. doi:10.1192/bjp.153.1.44

Lewis, K. L., & Grenyer, B. F. (2009). Borderline personality or complex posttraumatic stress disorder? An update on the controversy. *Harvard review of psychiatry*, *17*(5), 322-328.

Lieb, K., Völlm, B., Rücker, G., Timmer, A., & Stoffers, J. M. (2010). Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. *The British Journal of Psychiatry, 196*(1), 4-12.

Ligiéro, D. P., & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory, research, practice, training, 39*(1), 3.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY, US: Guilford Press.

Linehan, M. M. (1998). An illustration of dialectical behavior therapy. *In Session Psychotherapy in Practice, 4*(2), 21-44.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American journal of Sociology, 92*(6), 1461-1500.

MacIntosh, H. B., Godbout, N., & Dubash, N. (2015). Borderline personality disorder: Disorder of trauma or personality, a review of the empirical literature. *Canadian Psychology/Psychologie canadienne*, *56*(2), 227.

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of mental health*, *12*(6), 595-612.

Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staffs perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology, 42*, 243-256. doi:10.1348/01446650360703366.

McCusker, L., Chambers, K., Allen, G., Woods, E. & Bowri, M. (2018). Finding the middle ground: Working with people with long-standing interpersonal difficulties. *Clinical Psychology Forum, 303*, 13-18.

McCusker, L., Turner, M. L., Pike, G., & Startup, H. (2018). Meaningful Ways of Understanding and Measuring Change for People with Borderline Personality Disorder: A Thematic Analysis. *Behavioural and cognitive psychotherapy*, *46*(5), 528-540.

McGrath, B., & Dowling, M. (2012). Exploring registered psychiatric nurses' responses towards service users with a diagnosis of borderline personality disorder. *Nursing Research and Practice*, *2012*.

McGregory, R. (2010). *Borderline Personality Disorder and helpful service relationships: a grounded theory study* (Unpublished doctoral thesis). Salomons, Canterbury Christchurch.

Montgomery, C., Lloyd, K., & Holmes, J. (2000). The burden of personality disorder: A district-based survey. *International journal of social psychiatry*, *46*(3), 164-169.

Moore, E. (2012). Personality disorder: its impact on staff and the role of supervision. *Advances in psychiatric treatment, 18*(1), 44-55.

Moran, P., Jenkins, R., Tylee, A., Blizard, R., & Mann, A. (2000). The prevalence of personality disorder among UK primary care attenders. *Acta Psychiatrica Scandinavica, 102*(1), 52-57.

Morris, C., Smith, I., & Alwin, N. (2014). Is contact with adult mental health services helpful for individuals with a diagnosable BPD? A study of service users views in the UK. *Journal of Mental Health*, *23*(5), 251-255.

National Institute for Clinical Excellence. (2006). *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance*. NICE: London.

National Institute for Clinical Excellence. (2009). *Borderline personality disorder: recognition and management.* NICE; London.

National Institute for Clinical Excellence. (2015). *Personality disorders: borderline and antisocial. Quality standard*. NICE; London.

National Institute for Mental Health for England (2003) *Personality Disorder: no Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder*, Gateway Reference 1055. London: NIMH(E).

Nolte, T., Bolling, D. Z., Hudac, C., Fonagy, P., Mayes, L. C., & Pelphrey, K. A. (2013). Brain mechanisms underlying the impact of attachment-related stress on social cognition. *Frontiers in human neuroscience*, *7*, 816.

Ng, F. Y., Bourke, M. E., & Grenyer, B. F. (2016). Recovery from borderline personality disorder: a systematic review of the perspectives of consumers, clinicians, family and carers. *PloS one*, *11*(8), e0160515.

Ociskova, M., Prasko, J., Latalova, K., Sedlackova, Z., Kamaradova, D., Sandoval, A., & Grambal, A. (2017). F* ck your care if you lable me! Borderline personalitu disorder, stigma, and self-stigma. *Activitas Nervosa Superior Rediviva, 59*(1), 16-22.

O'Connor, K., Neff, D. M., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74-99.

Olabi, B., & Hall, J. (2010). Borderline personality disorder: current drug treatments and future prospects. *Therapeutic advances in chronic disease, 1*(2), 59-66.

Paris, J. (2004). Is hospitalization useful for suicidal patients with borderline personality disorder? *Journal of personality disorders, 18*(3: Special issue), 240-247.

Paton, C., Crawford, M. J., Bhatti, S. F., Patel, M. X., & Barnes, T. R. E. (2015). The use of psychotropic medication in patients with emotionally unstable personality disorder under the care of UK mental health services. *The Journal of clinical psychiatry, 76*(4), 512-518.

Perkins, A., Ridler, J., Browes, D., Peryer, G., Notley, C., & Hackmann, C. (2018). Experiencing mental health diagnosis: a systematic review of service user, clinician, and carer perspectives across clinical settings. *The Lancet Psychiatry*, *5*(9), 747-764.

Perseius, K. I., Kåver, A., Ekdahl, S., Åsberg, M., & Samuelsson, M. (2007). Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms. *Journal of Psychiatric and Mental Health Nursing, 14*(7), 635-643.

Pilgrim, D. (2001). Disordered personalities and disordered concepts. *Journal of Mental Health*, *10*(3), 253-265.

Polnay, A., MacLean, C., Lewington, E., & Patrick, J. (2015). A pilot before-and-after study of a brief teaching programme for psychiatry trainees in mentalizing skills. *Scottish medical journal, 60*(4), 185-191.

Ramon, S., Castillo, H., & Morant, N. (2001). Experiencing personality disorder: a participative research. *International Journal of Social Psychiatry*, *47*(4), 1-15.

Rogers, B., & Acton, T. (2012). 'I think we're all guinea pigs really': a qualitative study of medication and borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, *19*(4), 341-347.

Rogers, B., & Dunne, E. (2011). 'They told me I had this personality disorder… All of a sudden I was wasting their time': Personality disorder and the inpatient experience. *Journal of mental health*, *20*(3), 226-233.

Rosenbach, C., & Renneberg, B. (2014). Rejection sensitivity as a mediator of the relationship between experienced rejection and borderline characteristics. *Personality and Individual Differences, 69,* 176-181.

Rothschild, L., Cleland, C., Haslam, N., & Zimmerman, M. (2003). A taxometric study of borderline personality disorder. *Journal of Abnormal Psychology, 112*(4), 657.

Ryle, A. (2004). The Contribution of Cognitive Analytic Therapy to the Treatment of Borderline Personality Disorder. *Journal of Personality Disorders, 18*(1), 3-35. doi:10.1521/pedi.18.1.3.32773

Saunders, K. E., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review. *Journal of affective disorders*, *139*(3), 205-216.

Sansone, R. A., & Sansone, L. A. (2013). Responses of mental health clinicians to patients with borderline personality disorder. *Innovations in Clinical Neuroscience, 10*(5-6), 39-43.

Sauer, E. M., Lopez, F. G., & Gormley, B. (2003). Respective contributions of therapist and client adult attachment orientations to the development of the early working alliance: A preliminary growth modeling study. *Psychotherapy Research*, *13*(3), 371-382.

Sempertegui, G. A., Karreman, A., Arntz, A., & Bekker, M. H. (2013). Schema therapy for borderline personality disorder: A comprehensive review of its empirical foundations, effectiveness and implementation possibilities. *Clinical psychology review*, *33*(3), 426-447.

Sisti, D., Segal, A. G., Siegel, A. M., Johnson, R., & Gunderson, J. (2016). Diagnosing, disclosing, and documenting borderline personality disorder: a survey of psychiatrists' practices. *Journal of personality disorders*, *30*(6), 848-856.

Simons, J. S. & Gaher, R. M. (2005). The Distress Tolerance Scale: Development and validation of self-report measure. *Motivation and Emotion, 29*(2), 83-102.

Shanks, C., Pfohl, B., Blum, N., & Black, D. W. (2011). Can negative attitudes toward patients with borderline personality disorder be changed? The effect of attending a STEPPS workshop. *Journal of personality disorders*, *25*(6), 806-812.

Shapiro, E. R. (1978). The psychodynamics and developmental psychology of the borderline patient: A review of the literature. *Am J Psychiatry*, *135*(11).

Shaw, C., & Proctor, G. (2005). I. Women at the margins: A critique of the diagnosis of borderline personality disorder. *Feminism & Psychology, 15*(4), 483-490.

Smith, A. E., Msetfi, R. M., & Golding, L. (2010). Client self rated adult attachment patterns and the therapeutic alliance: A systematic review. *Clinical psychology review*, *30*(3), 326-337.

Smith, M. J., Bouch, J., Bradstreet, S., Lakey, T., Nightingale, A., & O'Connor, R. C. (2015). Health services, suicide, and self-harm: patient distress and system anxiety. *The Lancet Psychiatry*, *2*(3), 275-280.

Stalker, K., Ferguson, I., & Barclay, A. (2005). It is a horrible term for someone': service user and provider perspectives on 'personality disorder. *Disability & Society*, *20*(4), 359-373.

Starcevic, V., & Janca, A. (2018). Pharmacotherapy of borderline personality disorder: replacing confusion with prudent pragmatism. *Current opinion in psychiatry*, *31*(1), 69-73.

Stern, A. (1938). Pshoanalytic investigation and in the borderline group of nervoses. *Psychoanal. Quart, 7*.

Stoffers-Winterling, J. M., Völlm, B. A., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*(8).

Stroud, J., & Parsons, R. (2013). Working with borderline personality disorder: A small-scale qualitative investigation into community psychiatric nurses' constructs of borderline personality disorder. *Personality and Mental Health, 7*(3), 242-253. doi:10.1002/pmh.1214

Sulzer, S. H., Jackson, G., & Yang, A. (2016). Borderline Personality Disorder and the Biomedical Mismatch. In *50 Years After Deinstitutionalization: Mental Illness in Contemporary Communities* (pp. 263-290): Emerald Group Publishing Limited.

Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the prevalence of borderline personality disorder in the community. *Journal of personality disorders, 4*(3), 257-272.

Taylor, T. L., Hawton, K., Fortune, S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: systematic review. *The British Journal of Psychiatry*, *194*(2), 104-110.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of general psychiatry, 58*(6), 590-596.

Treloar, A. J. C. (2009). A qualitative investigation of the clinician experience of working with borderline personality disorder. *New Zealand Journal of Psychology, 38*(2), 30-34.

Tyrer, P. (1999). Borderline personality disorder: a motley diagnosis in need of reform. *The Lancet, 354*(9196), 2095-2096.

Undrill, G. (2007). The risks of risk assessment. *Advances in Psychiatric Treatment*, *13*(4), 291-297.

Veysey, S. (2014). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kotuitui: New Zealand Journal of Social Sciences Online, 9*(1), 20-35.

Warrender, D. (2015). Staff nurse perceptions of the impact of mentalization-based therapy skills training when working with borderline personality disorder in acute mental health: a qualitative study. *Journal of psychiatric and mental health nursing*, *22*(8), 623-633.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological review, 92*(4), 548.

Welstead, H. J., Patrick, J., Russ, T. C., Cooney, G., Mulvenna, C. M., Maclean, C., & Polnay, A. (2018). Mentalising skills in generic mental healthcare settings: can we

make our day-to-day interactions more therapeutic?. *BJPsych bulletin*, *42*(3), 102-108.

Westwood, L., & Baker, J. (2010). Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: a review of the literature. *Journal of Psychiatric and Mental Health Nursing, 17*(7), 657-662. doi:10.1111/j.1365-2850.2010.01579.x.

Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the relationship between burnout and empathy in healthcare professionals: A systematic review. *Burnout Research*, *6*, 18-29.

Wilstrand, C., Lindgren, B. M., Gilje, F., & Olofsson, B. (2007). Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm. *Journal of Psychiatric and Mental Health Nursing*, *14*(1), 72-78.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*(1), 54-65.

Woollaston, K., & Hixenbaugh, P. (2008). 'Destructive Whirlwind': nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, *15*(9), 703-709.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., & Silk, K. R. (2003). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *American Journal of Psychiatry, 160*(2), 274-283.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., & Silk, K. R. (2004). Mental health service utilization by borderline personality disorder patients and Axis II comparison subjects followed prospectively for 6 years. *The Journal of clinical psychiatry*.

Service Improvement Project

Resourcing, Engagement, Measurement of Effectiveness and Service User Feedback for Mentalisation-Based Therapy for Borderline Personality Disorder in a Secondary Care Service

Rebecca Sired

Doctorate in Clinical Psychology

Department of Psychology, University of Bath, Claverton Down

Bath, BA2 7AY

r.sired@bath.ac.uk

June 2019

Word count: 5328words

Internal Supervisor: Dr Elizabeth Marks, Clinical Tutor and Lecturer, Doctorate in Clinical Psychology Programme, Department of Psychology, University of Bath, e.marks@bath.ac.uk

External Supervisor: Dr Jennie Boland, Clinical Psychologist, Avon and Wiltshire Mental Health Partnership NHS Trust, jennie.boland@nhs.net

Proposed Journal for Publication: Personality Disorders: Theory, Research, and Treatment. This journal publishes a wide range of original research relating to personality disorders and related psychopathology including papers bridging practice and science (Appendix A).

Abstract

Mentalisation-Based Therapy (MBT) is an 18-month psychological intervention developed for people with a diagnosis of borderline personality disorder. MBT has emerging evidence for effectiveness (Malda-Castillo, Browne, & Perez-Algorta, 2018) but less research pertaining to SU experience and implementation in NHS services. This study evaluated resourcing, engagement, proposed methods of measuring effectiveness and SU experience of MBT in a secondary care service, and identified potential service improvements. Overall, results indicated that resourcing for the programme and uptake and retention of SUs were lower than anticipated. Weekly and six-monthly qualitative questionnaire feedback from the six SUs who did progress to the full MBT programme was analysed using content analysis. Findings reflected topics reported by other researchers, pertaining to positive benefits and challenges of MBT and highlighted issues around low acceptability of procedures for evaluating outcomes, and the impact of limited service resources. The necessity to ensure sufficient resourcing of services offering MBT and issues around engagement and measuring outcomes are highlighted, and limitations discussed.

Keywords: MBT, Borderline Personality Disorder, Service Improvement, Feedback, Engagement

Introduction

The diagnosis of borderline personality disorder (BPD) is associated with difficulties in emotion regulation, impulse control, interpersonal functioning, and an unstable or underdeveloped sense of self (APA, 2013). Reported prevalence rates for BPD in the general population are 1.4% (Coid et al., 2009), with one study of a London community mental health team finding 52% of their caseload would meet diagnostic criteria for personality disorder (Keown, Holloway, & Kuipers, 2002). Suicidal ideation is common, with up to three-quarters attempting suicide at least once (Black, Blum, Pfohl, & Hale, 2004). Historically, evidence-based treatments for BPD were lacking, however some psychological interventions now have a growing research base supporting their effectiveness (Stoffers et al., 2012). The National Institute of Clinical Excellence (NICE, 2009) recommends psychological treatment for longer than three months and suggests mentalisation-based therapy (MBT) may be beneficial for BPD.

Mentalisation-Based Therapy (MBT)

MBT is a manualised psychological treatment focused on relational processes and based on psychodynamic and attachment theories (Bateman & Fonagy, 1999). MBT is preceded by attending a 12-week introductory group (MBTi) involving psychoeducation about BPD, socialisation to the model, assessment of mentalising capacities and motivation for full MBT treatment. Upon completion of MBTi, service users (SUs) can begin the 18-month structured MBT programme, as detailed in Bateman and Fonagy (2016). This involves weekly group and individual sessions and intends to increase people's ability to mentalise. Mentalisation or 'reflective function' is defined as the ability to understand our own and others actions in terms of internal mental states (Bateman & Fonagy, 2016). The group functions as a 'training ground' for mentalising, with the task of responding to the minds of multiple others proposed to make the group among the most challenging aspects of MBT (Bateman & Fonagy, 2016).

Theory of Mentalisation-Based Therapy

MBT theory suggests the difficulties associated with BPD are mediated through decreased mentalising, particularly when distressed (Bateman & Fonagy, 2010). MBT proposes that the development of mentalising abilities depends on our internal states being adequately understood by attuned caregivers as infants (Fonagy & Bateman, 2007). Insecure attachment is often associated with BPD (Levy, 2005), and therefore people with

these difficulties may be less likely to have developed robust mentalising capacities and be more vulnerable to loss of mentalising (Badoud et al., 2017). The primary aim of MBT is to increase people's ability to mentalise (Fonagy & Bateman, 2007), and success is proposed to depend upon consistent and structured application of the core treatment principles by individual therapists, the team and within the service or institution (Bateman, Bales & Hutsebaut, 2018).

Evidence Base and the NHS

A systematic review of MBT across different clinical presentations concluded that although evidence is only emerging, most studies of MBT for BPD demonstrate positive clinical outcomes (Malda-Castillo et al., 2018). For example, a randomised control trial (RCT) in a partial-hospital setting reported significant improvements to suicidality, self-harm, and interpersonal and mood-related outcomes comparative to TAU (Bateman & Fonagy, 2001). Many benefits were sustained eight years later (Bateman & Fonagy, 2008). When applied to outpatient settings, a controlled single-blind study showed MBT was more effective in reducing depression and self-harm than structured clinical management (Bateman & Fonagy, 2009). Another systematic review found MBT for BPD to be equal or superior to more established psychological interventions in reducing psychiatric symptoms (Vogt & Norman, 2018). Both reviews reported the quality of existing studies to be poor (Malda-Castillo et al., 2018; Vogt & Norman, 2018). More recently, a randomised multi-centre clinical trial comparing day-hospital MBT with intensive outpatient MBT found significant improvement on BPD symptom severity in both groups (Smits et al., 2019).

In line with NICE (2009) recommendations that treatments are a minimum of three months, MBT was developed as a 18-month programme. However, Vogt and Norman (2018) noted a wide range in length of MBT across studies, indicating that since the duration required for clinically significant change is not yet established and shorter MBT interventions could produce change.

Most RCTs assess intervention effectiveness under standardised and preferable conditions (Barkham, Hardy, & Mellor-Clark, 2010). Malda-Castillo et al. (2018) call for further investigation of MBT efficacy in routine clinical practice to draw more consistent funding from commissioners. Their review highlighted the lack of routine implementation of this approach within NHS mental health services despite growing literature supporting its

effectiveness (Malda-Castillo et al., 2018), demonstrated by MIND's report (2013) not citing MBT as a commonly offered treatment.

NICE (2009) states that clinicians frequently have difficulties maintaining engagement with people with BPD and drop-out is common. Research indicates similar issues, with many studies in Vogt et al.'s (2018) review reporting small samples and high attrition rates (7-54%). Little research has considered SU's experience of MBT; two small qualitative papers exploring the benefits and impact on individuals identified 'the battle of BPD and me' and 'the value of being understood' as key themes respectively (Dyson & Brown, 2016; Johnson, Mutti, Springham, & Xenophontes, 2016). Another identified four overarching themes: the group being challenging and unpredictable, building trust as a gradual but necessary process (and more difficult in group than individual sessions), making sense of MBT's structure and MBT helping them see the world differently (Lonargáin, Hodge, & Line, 2017).

Measuring Effectiveness in Psychological Interventions for BPD

BPD is heterogeneous, with diagnosis requiring the presence of five out of nine criteria (DSM V; APA, 2013). Outcome measures must therefore cover a breath of symptoms (Vogt & Norman, 2018). Suicidal and self-harm behaviours are common but not relevant for all (NICE, 2009). Consistent measurement of outcomes for people with BPD is lacking, and NICE (2009) call for development of valid and reliable measures of symptoms and functioning.

Emotional dysregulation and variability is a core feature of BPD (Glenn & Klonsky, 2009) so infrequent and one-off measures may be insufficient to capture individual's overall mental health or functioning or assess outcome. As advocated by Bateman and Fonagy (2016) in their MBT treatment guide, this issue could be mitigated by using weekly measures to examine trends over time. The successful use of weekly measures with this population has been demonstrated within STEPPS; a CBT-skills based group intervention for BPD (Blum, Pfohl, John, Monahan, & Black, 2002).

Little research assesses mechanisms of change and few studies measure reflective functioning abilities (Bateman & Fonagy, 2016; Vogt & Norman, 2018), despite development of self-report measures of mentalising (Cucchi, Hampton, & Moulton-Perkins, 2018; Fonagy et al., 2016). Themes arising from a qualitative study exploring the

experience of change in MBT (Morken, Binder, Arefjord, & Karterud, 2019) suggested increasing mentalising capacity as a key change process (Morken et al., 2019).

Aims of the Project

The primary objective of the study was to identify and test a method of evaluating effectiveness of a new MBT programme for adults with BPD in a routine NHS setting (a secondary care mental health service in South West England) over the first six-months. This was developed with the aim of setting up an ongoing, meaningful and sustainable evaluation strategy to support service development, commissioning and enhance therapeutic processes.

Initially the project had the secondary aim of evaluating the effectiveness and SU experience of the MBT program, with a view to informing future service developments to treatment processes and duration, in line with the Trust's Personality Disorder Strategy aims of quality assurance and cost-effectiveness. Following comprehensive consultancy with the service, the project was focused upon the group element of MBT, as this part of the treatment presented greater challenges than the individual element (in line with theory and existing research e.g. Bateman & Fonagy, 2016; Lonargáin et al., 2017). To meet this secondary aim, the project initially focused on (a) identifying if and when change occurred and (b) SU feedback regarding experience of the MBT group.

Due to unexpected recruitment difficulties and loss of staff availability to offer MBT, further consultancy with the service led to extension of the project from six to 12-months. Despite this significant extension, low uptake and high attrition meant data collection was insufficient to meet the secondary aims of assessing effectiveness and SU experience. Further service-level consultation led to new secondary aims: to assess flow through the MBT pathway and explore engagement, acceptability and feasibility of full MBT. The current study therefore aimed to answer the following questions to inform future service provision of MBT:

1. Is the service appropriately resourced to offer the full MBT programme?
2. What was SU uptake, retention and engagement throughout the whole MBT programme (MBTi and full MBT)?
3. Is the proposed method of measuring outcomes and eliciting feedback feasible, useful and acceptable to SUs?

4. If the programme continues to be offered, how could SU experience (and therefore potentially engagement) be improved?

Method

Study Setting

The MBT service was run by a secondary care mental health services therapies team in South West England. Following referral and initial assessment, suitable SUs with a diagnosis of BPD were invited to attend the 12-week MBTi group. Stand-alone MBTi had been available since 2016, but the full 18-month MBT programme was only offered from September 2017 following developments in the personality disorder treatment pathway and staff training.

After completing MBTi, SUs assessed as appropriate were invited to attend full MBT. This involved three components: (1) weekly 90-minute groups co-facilitated by a Clinical Psychologist and an Arts Psychotherapist experienced in MBT; (2) weekly one-hour individual sessions with a different therapist (except in one case, where the therapist was also running the group due to limited staffing); and (3) between-session, telephone-based mentalising support from a duty MBT therapist during office hours, as required. Additional cohorts joined the existing full MBT group approximately every six-months (after each MBTi group). SUs attended three-monthly reviews with a group facilitator and their individual therapist to consider engagement, progress towards their goals and review their formulation.

Ethical Approval

Full ethical approval was granted by the University of Bath Psychology Department Ethics Committee (ref: 17-194; Appendix C) and the Trust's Research and Development (R&D) team (ref: E2017.014; Appendix D). Three subsequent amendments to extend the project were given approval by the R&D team and Chairs Action on behalf of the Ethics Committee.

Design

A mixed-methods design was initially employed, collecting quantitative and qualitative questionnaire data from SUs. Additional data on uptake, retention, flow and staff training was later gathered from the service.

Participants

Six White-British women started the full MBT programme and gave written, informed consent. Four participants were from the first cohort in September 2016 and two from the second cohort, joining the group six months later. All participants reported long-term interpersonal difficulties consistent with the diagnostic criteria of BPD. Ages ranged from 23 to 46, with an average of 29 years. Three were unemployed, two were students and one worked part-time.

Measures

Review of the literature on outcome measures for BPD and consultation with the service led to selection of the below measures. Psychometric properties, evidence of acceptability and frequency of use with this group, and relevance to research aims were assessed and discussed before agreeing the final schedule of measures (Table 2.1).

The short version of the Borderline Symptom List (BSL-23) was initially considered for weekly use, however it was excluded due to its' length and as not developed for weekly administration (Bohus et al., 2009). Other common measures, such as the Zanarini Rating Scale (Zanarini, 2003), were excluded because the service required self-report scales. Staff consultation also led to development of the qualitative measures (Table 2.2).

Feedback on measures from two people with personal experience (PPE), both of BPD and one of MBT, led to changes in wording and layout, and a reduction in both quantity and frequency of quantitative questionnaires to minimize participant burden (from monthly to three-monthly). Collaboration with these individuals supported the design of the qualitative measures, aiming to enhance acceptability and clinical utility whilst retaining the ability to collect the feedback requested by the service. PPEs expressed preference for feedback via a questionnaire than an interview due to anonymity and burden concerns.

Quantitative

Table 2.1

Quantitative self-report measures

Administration Schedule	Measure	Details and Psychometric Properties
Weekly across baseline (pre-treatment) and treatment	Borderline Evaluation of Severity Over Time (BEST)	A 15-item measure of severity of thoughts, emotions and behaviours associated with BPD, initially developed for use within STEPPS programs to assess change. It has good reliability and validity (Cronbach's α = 0.86) and is appropriate for weekly use (Pfohl et al., 2009).
Weekly during treatment	Rating of how able they felt to mentalise in the group (on weekly qualitative feedback form)	A 7-point Likert scale, where 0 is 'Not at all' and 7 is 'Extremely able'.
Three-monthly	Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM)	A valid and reliable 34-item measure of trans-diagnostic psychological distress (Connell et al., 2006), with strong internal reliability (Cronbach's α = 0.94) (Evans et al., 2002).
	Reflective Functioning Questionnaire (RFQ-8)	An 8-item self-report measure of mentalising with two subscales: uncertainty and certainty about mental states (Fonagy et al., 2016). It has strong test-retest reliability and adequate internal reliability for both subscales (Cronbach's α = 0.77 and 0.65 respectively).
	Work and Social Adjustment Scale (WSAS)	A 5-item scale of functional impact of identified problem (Mundt, Marks, Shear, & Greist, 2002), with good internal consistency (Cronbach's α ranging from 0.70 to 0.94).

Qualitative

Table 2.2

Qualitative self-report measures (see Appendix G & H)

Administration Schedule	Questionnaire	Details
Weekly	MBT Programme Weekly Feedback Form	A 6-item feedback form with open-ended questions; three asking for feedback on helpful, unhelpful aspects/improvements and learning from the group and three asking about self-reported self-harm, suicide attempts and hospital admissions (psychiatric and A&E) over the last week.
Six-monthly	MBT Programme six Month Feedback Form	An anonymous 7-item feedback form with open-ended questions asking about their experience of the programme over the last six months. Specifically; what helped and hindered mentalising, possible improvements, experience of people joining the group, process of completing outcome measures, their participation in the programme and other suggestions/comments.

Interviews. In light of evidence in the literature of poor engagement with MBT for BPD, the study was designed to try and capture information from SUs who dropped out of treatment. Semi-structured interviews were offered to all SUs who dropped out of full MBT, either in person or over the phone (Appendix I). They were to be audio-recorded and expected to last approximately 30 minutes. This method was selected following consultation with the team and PPEs, aiming to ensure consistency in questions whilst affording flexibility to follow-up on any comments with particular relevance to the study's aims.

Procedure

All participants who joined full MBT in September 2017 provided written, informed consent. The BEST questionnaire was completed on four consecutive weeks prior to session one of the programme to provide a baseline for comparison. Weekly and three-monthly measures were administered at the end of the MBT group by facilitators. The anonymous six-month qualitative feedback questionnaire was administered by the researcher at six and 12-months without the facilitators present. The researcher attended the service bi-monthly to check measure completion and enter data. SUs who stopped attending the MBT programme were contacted by the researcher approximately a month

later and invited to be interviewed. Since uptake and retention for the first cohort was significantly lower than expected (predicted: n=8, actual: n=4, reducing to 3), the project was extended by six months to include additional data and the second cohort (predicted: n=6, actual: n=2).

Risk Management

Rates of self-harm and suicidality are high within BPD populations (Black et al., 2004; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994). The group therapists assessed, monitored and responded to any risks, including reviewing relevant measures. During collection of baseline data weekly reminder emails were sent to SUs and scores reviewed regularly by care co-ordinators. A statement was added to the BEST measure encouraging participants to follow their crisis/care plan and how to seek support if their score indicated self-harm or suicidal feelings.

Analysis to Answer Corresponding Aims:

1. To evaluate resourcing of MBT and potential impact on service provision, staff flow and training was analysed over 12-months.

2. To evaluate SU uptake and retention, SU flow across MBTi and full MBT was analysed over 12-months. Engagement was considered using rates of full MBT group attendance, calculated by dividing number of sessions attended by total sessions offered per person, and interview uptake.

3. & 4. To assess the feasibility and acceptability of the proposed evaluation method and consider SU experience of helpful aspects and possible improvements to the programme, both quantitative and qualitative methods were used. The outcome measure completion rates were calculated per person by dividing the total times completed by number of group sessions attended over the 52-week project period. Data from qualitative SU weekly and six-monthly feedback was collated and analysed using inductive content analysis based on guidance by Elo and Kynga¨s (2008). This content analysis approach was used to identify the occurrence of concepts (implicit and explicit) within the data. This involved coding, grouping codes into sub-categories and then formulating these into main categories (abstraction).

Results

Resourcing and Service Provision

Although eight multi-disciplinary staff were funded for training to deliver MBT, there was significant staff attrition over the 12-month period of the project with three trained staff leaving the service (Figure 2.1). One staff member did not see any MBT clients as they specialised in older adults, and the only older adult offered MBTi subsequently dropped out. Despite funding being requested to train three additional clinicians this was only granted for one, limiting MBT delivery to five staff. To manage reduced staffing levels one staff member subsequently delivered both group and individual therapy, contradictory to the MBT model.

Unexpectedly poor staffing levels had two significant impacts. Firstly, the service was advised to limit the numbers of people offered MBTi, reducing patients who would then be eligible for full MBT. Secondly, increased workloads across the team meant MBT-trained staff did not have sufficient protected time to offer a fully-staffed MBT duty line.

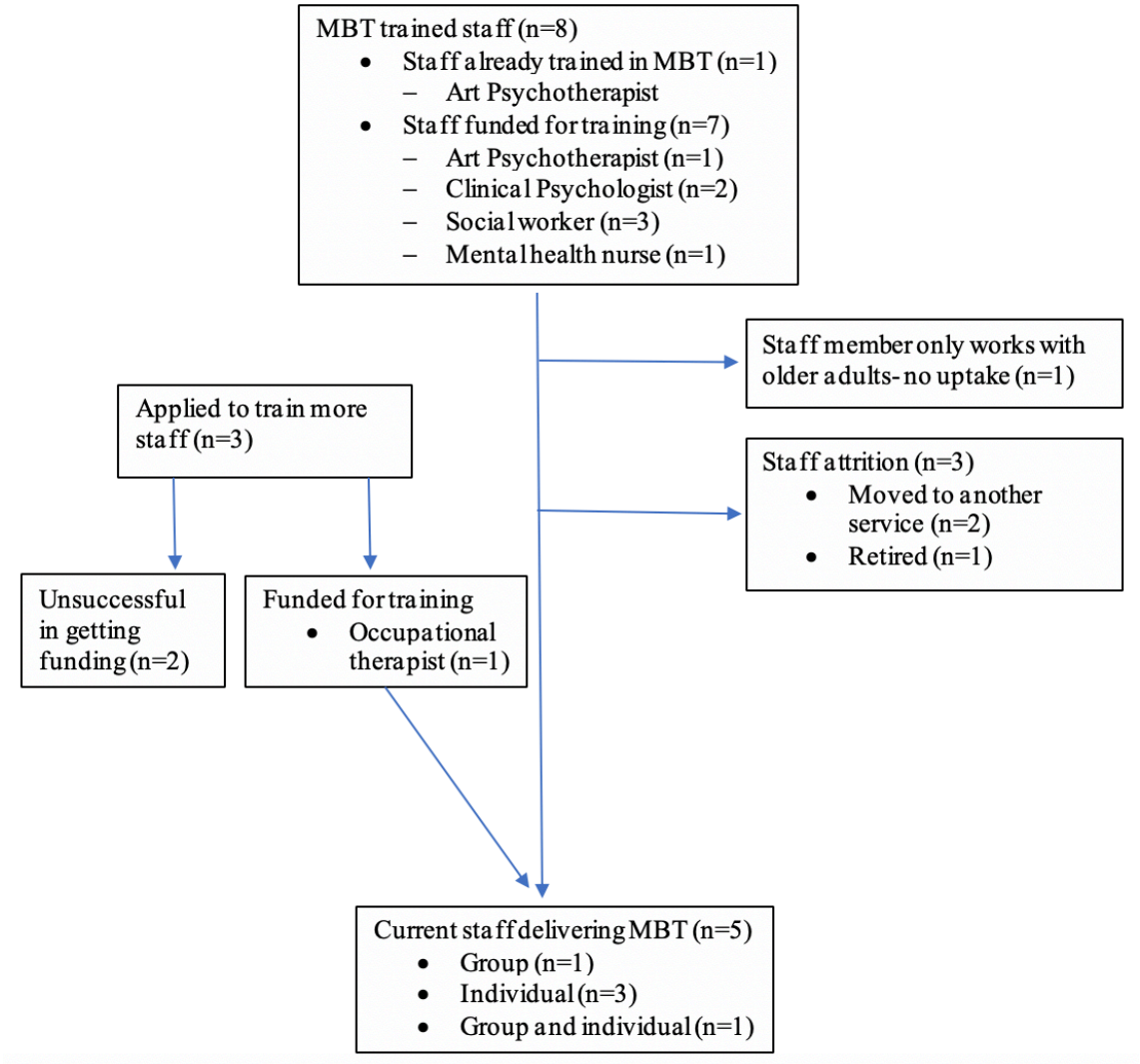

Figure 2.1: Staff training and retention for the MBT programme over 12 months

Uptake, Retention and Engagement

Based on estimated referrals from the waiting list and recommendations for maximum group numbers by Bateman and Fonagy (2016), the service anticipated eight people would join full MBT in September 2017 (cohort 1). However, only four entered full MBT (Figure 2.2) and only three remained after six weeks. This was due to lower than expected uptake and completion of initial MBTi (predicted: n=10, actual: n=7), a lower than expected proportion of MBTi patients being referred onto full MBT (predicted: 80%, actual: 57%; 4/7) and one subsequent drop-out. This indicated a need to extend the project and reconsider the scope and aims of the study.

Extension of six months led to the inclusion of a second cohort in March 2018. After project aims shifted following continued low numbers, flow of SUs through MBT over one year and three cohorts was assessed. A total of 20 people were offered MBTi; 17 completed this and were assessed for full MBT. Of these, nine (53%; 9/17) were not deemed appropriate for full MBT (three required alternative intervention, two stepped down to primary care, two were discharged, one recovered and one required ongoing assessment). Of the remaining eight (47%; 8/17) offered full MBT, six commenced the programme. Two others were suitable, however one moved away and the other could not be offered treatment as poor staffing levels meant no individual MBT therapist was available. Notably, the proportion of people offered full MBT after successful completion of MBTi reduced for each subsequent cohort (5/6 in cohort 1, 2/5 in cohort 2 and 1/6 in cohort 3).

Of the six commencing full MBT, one left after six weeks, and another after 10 months but re-joined two months later. Both declined to complete the planned interviews. Group attendance for the five remaining SUs at 12 months was good, ranging from 83% (38/45 sessions over 12 months) to 100% (17/17 sessions over 6 months) (mean %= 89, 155/175 sessions).

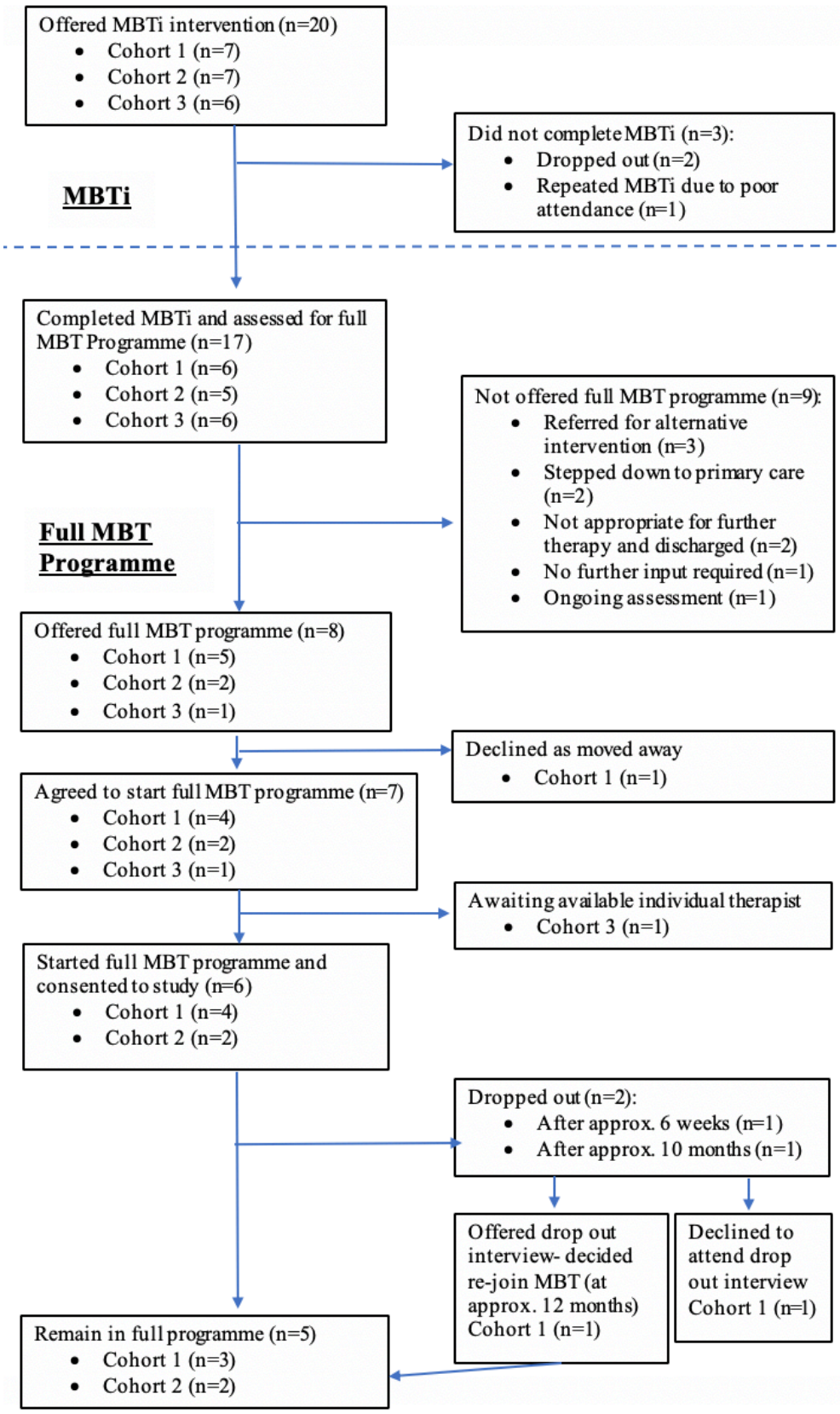

Figure 2.2: Flow of SUs through the MBT programme over 12 months

Measure Completion Rates

Quantitative measures. Completion rates for the weekly measures were low, ranging from 9% (2/23 sessions) to 44% (20/45 sessions) per person. When response rates of participants were considered together, measures were completed an average percentage of 34% of group sessions (60/175, n=5). Measures were completed more frequently in the first six months of the project (mean % =78; 51/65, range: 72%; 13/18 to 90%; 18/20, n=4), but substantially reduced after this initial period (following six months: mean % =14; 13/95, range: 11%; 2/19 to 18%; 3/17, n=5). The three-monthly quantitative measures were more consistently completed across the 12-months (mean % =83; 18/21, range: 67%; 2/3 sessions over 6 months, to 100%; 5/5 sessions over 12 months, n=5).

Qualitative measures. The weekly qualitative feedback questionnaire was completed an average percentage of 38% (66/175 sessions) over the 12-months (range: 13%; 3/23 sessions to 47%; 21/45 sessions, n=5), again decreasing over the duration of the project. It was completed an average percentage of 75% (49/65) of attended sessions in the first six months (range: 67%; 12/18 to 85%; 17/20, n=4), but only an average percentage of 22% (21/95 sessions) over the following six months (range: 17%; 3/18 to 29%; 5/17, n=5).

The six-monthly feedback questionnaire was completed by all three participants at six-months (cohort 1) and four out of five participants at 12-months (cohort 1: n= 3, cohort 2: n=1). Data were combined and analysed together. Response rates were lowest for question 3 ("Is there anything you would change in the group or individual sessions that would improve your ability to mentalise?"), with only 3/7 providing feedback for this question. All other questions were answered on six or all of the seven completed questionnaires.

Content Analysis of Service User Experience

Weekly feedback. Three main categories were identified: *'valuable and challenging aspects of group'*, '*contributing and helping each other'* and '*building open and trusting relationships outside therapy'* (Table 2.3).

Valuable and challenging aspects of group. Participants noted benefitting from gaining new perspectives and ways to deal with difficulties. They also identified the importance of feeling heard and understood without judgement by others. Some spoke

about therapy being helpful when distressed, whereas others reported finding it more challenging to mentalise in the group when upset. Responses relating to being questioned in the group were more mixed, with some reporting this as helpful but others experiencing it as too challenging. Interestingly, two people requested further clarity about what mentalising is.

Contributing and helping each other. The most frequent comment was the importance of talking more in the group sessions; speaking honestly and asking others questions, with some people reporting worries about other's reactions being a barrier to this. Other group members highlighted sharing as valuable, and helping others mentalise.

***Building open and trusting relationships outside therapy*.** Many responses referred to an increased desire to connect openly with others in their lives, build trust and ask others for help.

Table 2.3

Main and sub-categories from weekly SU feedback about the MBT group

Main Category	Sub-Category	Count	Examples
Valuable and challenging aspects	Gaining new perspectives and ideas	11	"…makes me think from a different perspective" "(group member) helped me see things from (family member's) point of view" "Was able to rationalise my thoughts" "Advice and ideas given about my problems help in dealing with issues that arrive"
	Association between mentalising and distress	8	"I couldn't really mentalise at all because of how upset I was" "I didn't want to come to the group in the morning but I mentalised and told myself to go. I felt MUCH better for going" "I had a good week which helped in the group. I felt I was able to contribute more" "That it can be ok to be upset"
	Questioning versus challenging	7	"I felt like I was being challenged in a way that came across as being 'ganged up' on" "People asking me questions helped"
	Feeling heard and understood without judgement	4	"I felt as though people were listening to me better rather than judging me" "People could have listened to me better. Maybe come across they understood more"
	Understanding of mentalising	2	"Please expand on what mentalising actually is"

	More members as positive	1	"More people in group would be good"
Contributing and helping each other	Talking more (despite concerns about others' reactions)	27	"To contribute more in the session and to not be afraid of speaking even though it may be difficult i.e. if I say something wrong" "I should have answered more questions… contributed a bit more" "Trying to be more honest"
	Others sharing useful	4	"People opened up more… people asked me questions" "People that normally don't share talked more"
	Value of helping others	4	"I was able to help another member in the group to mentalise" "I can say stuff other people might find useful"
Building open and trusting relationships outside therapy	Connecting with people and feelings	14	"Caring about others and showing feelings" "Being open with other people. Trying to trust others" "When I am feeling in a dark place I should open up more no matter how hard it is"
	Seeking support	2	"Try not to worry about asking for help twice" "Get in touch and use care co-ordinator"

Six-Monthly Feedback. Four main categories were evident within participant's feedback (Table 2.4). Two echoed that seen in the weekly data: '*valuable and challenging aspects'* and *'contributing and helping each other'*, however two new categories were also apparent: '*service resourcing'* and '*data collection issues'*.

Valuable and challenging aspects. Participants continued to reflect on the importance of feeling heard and understood without judgement and building trusting relationships, and again requested more members. An additional sub-category showed new joiners to the group were managed well by therapists. However, participants indicated concerns about therapists sharing details from duty line conversations in the group without discussing with the SU involved.

Contributing and helping each other. Consistent with the weekly feedback, others sharing in the group and talking with others and getting their feedback were both highlighted as useful.

Service resourcing. Notably, issues with staffing appeared to directly impact on participant's experience of MBT. In particular, the duty line was frequently cited as an aspect requiring improvement, with participants reporting call-backs as inconsistent and requesting clearer communication around staff availability. Participants also commented

that other staff were not aware of MBT which impeded access to support as admin staff did not know who to direct their calls to, as did a lack of policy regarding follow-up after group non-attendance. Change of individual therapist due to staff attrition was reported as problematic and “like starting again” demonstrating the importance of a strong therapeutic relationship in line with the MBT model.

Data collection issues. Participant burden was frequently mentioned, particularly regarding too many and too frequent questionnaires and feedback forms, when little changed for them each week. They disliked completing measures and struggled to think of qualitative responses, especially on a weekly basis. Notably, not all questions felt relevant for everyone, meaning people either felt singled out or felt the questions were pointless. Negative impacts of recording self-harm incidences was reported. Feedback indicated potential bias in the quantitative data, describing how they recalled answers from the previous week and would tend to purposely score the same. The small sample size potentially compromised anonymity and participants reported concerns about being identifiable as a barrier to giving honest feedback.

Table 2.4
Main and sub-categories from six-monthly SU feedback about the MBT programme

Main Category	Sub-Category	Count	Examples
Valuable and challenging aspects	Building trusting relationships	5	"Trusting the members of the group" "Helps if build up rapport (e.g. known them for longer) … spoke to individual therapist about things not talked about in group" "…it's harder to speak about hard stuff (i.e. self-harm and dying) in front of new people, because I don't know how they will react"
	Good communication about new joiners	5	"They told us long before the new person arrived and talked about it in the group. They asked us how we felt and tackled any problems we have"
	More members as positive	3	"More members would be good" "I didn't mind new faces, liked meeting new people"
	Feeling heard and understood without judgement	3	"…I felt as though people weren't listening to what I was saying, sometimes I felt judged" "Sometimes feel criticised by the therapists, not listened to. Feeling other members of the group won't agree with me or want my input"
	Therapists sharing with group without individuals' consent	2	"Don't say/announce to everyone in the group that you have called and what you said- it makes me only phone for "easy" stuff I don't mind everyone in the group knowing"
Contributing and helping each other	Others sharing useful	3	"Sometimes it's easier to think about other peoples' stuff than my own stuff" "Other people opening up helped"
	Talking with others	2	"Good to talk about problems and get others feedback"
Service resourcing	Duty line consistency and availability	5	"Make people phone back consistently- it takes guts to phone up and it is stressful waiting for a phone call so it just makes things worse…" "Call and say a time they will call again or let me know a time to call back" "…if there is no duty person that day it might have been helpful for someone to tell me that because waiting for a phone call is stressful. Especially if it doesn't happen" "Knowing who is on duty might make me use it more, would prefer to speak to individual therapist"
	Impact of individual therapist leaving	2	"Is about the relationship not just having a good handover- new person for individual therapy feels like starting again"
	Staff awareness of MBT	1	"Teach the receptionists what MBT is so that if you phone the duty person it's not a battle"

	Welfare calls	1	“When people are off for a week I think it should be standard practice for therapist to call to check in. I had one week off and wasn’t called when I could really have done with some support”
Data collection issues	Burden	3	“Tedious, too many forms, one would have been ok”
	Challenge of thinking on the spot (qualitative questions)	3	“I hate the questionnaires because I never know what to write (for the written questions)” “I didn’t like filling them out and really struggled every week. Number or yes/no questions were easier and I didn’t mind so much” “On the one you have to write answers on I can never think of what to say right at that moment, but sometimes I think of something when I get home so would have been better to take it home then bring it back next week”
	Questions not relevant for all	3	“I hate doing the forms and they seem really pointless- partly because on one of them (the tick box one) most of the questions I don’t really relate to” “Stop focusing only on self-harm because it feels like I’m being singled out because it’s something I struggle with and other people don’t so much”
	Lack of weekly change	3	“Not much changes over a week, monthly would be better” “Once a month instead of weekly… partly because I remember what the answers are because we do them so often, so I go on autopilot and then the answers are always the same”
	Negative impact of answering self-harm questions	2	“I don’t like writing down numbers about how many times I’ve self-harmed etc. because then my stupid head keeps wanting to beat it (in the wrong way i.e. self-harm more) … so I stopped answering those questions and just ticked the boxes”
	Anonymity concerns	2	“Feel aware that facilitators read them after we leave so don’t put lots of things down” “Can’t give some feedback I want to as they would know who it is from even if anonymise”

Interviews. Both SUs who dropped out of the programme were offered interviews, but neither chose to participate. One initially agreed but did not attend and the other decided to return to MBT during the initial telephone conversation with the researcher. This SU commented that being invited to think about their reasons for disengaging with the programme gave them space to reflect on what they found helpful about it. They said the conversation's supportive nature reminded them of their lack of social support and potential role of the programme in providing this.

Discussion

This study aimed to provide information about service resourcing and uptake, engagement and retention rates and assess a method of gathering data on effectiveness and SU experience of MBT in a secondary care service, in order to suggest improvements. Findings indicated that resourcing for the programme and uptake and retention of SUs were lower than anticipated, but those who progressed to full MBT had high attendance rates. Qualitative feedback indicated positive experiences within MBT, as well as some challenges. However, methods of collecting outcome data lacked acceptability, and possibly reliability.

Staff attrition, lack of protected time and subsequent limited funding to train additional staff appeared to affect programme delivery. Issues with low staffing levels can be seen in SU feedback regarding problems accessing support via the duty line and difficulties when individual therapist access changed. Considering the proposed importance of MBT core treatment principles being consistently applied across individual, team and service levels (Bateman, Bales & Hutsebaut, 2018), these issues are likely to reduce service quality and thus engagement and outcomes. MBT is a high intensity intervention that requires substantial resources to retain fidelity to the model, with low group numbers presumably increasing cost per patient. Therefore, consideration of the feasibility of offering this programme within this service without additional investment by the Trust or changes to enhance retention and referral rates may be merited.

Uptake of both MBTi and subsequent progression to the full MBT programme was sizeably less than expected, meaning numbers fell below the levels advised by the MBT practice manual (Bateman & Fonagy, 2016). The resulting low number of participants, with two further dropouts (although one re-joined), echo reviews where studies report that small samples and high attrition rates are common in MBT for BPD (Vogt & Norman, 2018). That

neither drop-out elected to engage in an interview highlighted the difficulties in obtaining feedback data from people who disengage from services. Although this small sample may not be representative, future groups could consider ways of collecting feedback from SUs who dropout.

Methods for measuring outcome were largely unacceptable and apparently limited in utility, with low response rates which declined further over six months. Weekly data collection was seen as burdensome and inappropriate by SUs, suggesting this was neither a feasible nor sustainable way to evaluate change for this MBT programme. Such frequency of data collection may also lead to issues with validity, based on SU feedback regarding response bias (with participants recalling and repeating previous answers). The impression that participant burden may have affected completion was shown both by low response rates and analysis of qualitative data from SUs that questionnaires were too frequent and too numerous. Literature which reports successful use of weekly measures with this population comes from shorter interventions (e.g. STEPPS: Blum et al., 2002), and this project tentatively suggests such an approach may not be as appropriate in longer-term interventions.

SU feedback that measures were not relevant for all is consistent with the heterogenous nature of BPD (APA, 2013), and findings mirror the challenges of measuring outcomes for this client group highlighted by NICE (2009) guidelines. When used therapeutically, benefits of using outcome measures have been reported, including improvements to motivation and therapeutic alliance (Youn, Kraus, & Castonguay, 2012). However, with administration in the group, potential for therapeutic reflection upon each participants' measures may have been limited, with less space to capture and work towards idiosyncratic goals for change. This may have reduced the perceived meaningfulness and subsequent motivation to complete these, further reducing therapeutic benefits.

Aside from data collection and service resourcing issues, qualitative data about SU experience of the MBT group chimed with themes emerging from previous research. For example, the challenges of being in a group, MBT bringing new perspectives and the importance of building trust were reported in Lonargain et al. (2017). Feeling understood was crucial for SUs, as described by Johnson et al. (2016). Additional topics were evident, including a focus on the specific benefits of the group format such as deriving value from

others sharing, assisting others to mentalise and the importance of everyone contributing. These are consistent with MBT ideas of mentalising being a reciprocal process and attachments with others providing a context from which to explore personal difficulties (Bateman & Fonagy, 2016), and may suggest further avenues for future qualitative researchers to explore. Despite completing the psychoeducational MBTi group, SU feedback suggests ongoing confusion about mentalising. It could be hypothesised that not feeling clear about the aim and change process of the intervention may potentially impact on engagement.

Recommendations and Feedback

Based on the findings the following recommendations were made, aiming to inform service delivery and improvements. These were fed-back to the MBT lead and wider service, and their responses are included in Table 2.5.

Table 2.5

Recommendations for service delivery and improvements, and service responses

Evaluation Recommendations	**Summary of Service Response**
To improve feasibility and completion rates: - Reduce number and frequency of outcome measures. Balance issues around emotional variability with risk of burden, for example by SUs completing measures for three consecutive weeks every three months. - Collect qualitative feedback at six-monthly intervals, as the themes from weekly feedback were mainly captured within this. - It may be useful to prompt reflection and consolidation of learning at the end of group or individual sessions, as an additional theme in weekly but not six-monthly feedback related to what they took away from the group (the importance of connecting to others outside therapy). - Give people the option to take away the qualitative measure and return it next time (to enable more time to reflect and consider their feedback).	- Findings relating to this primary aim of the project are very helpful, and the service will take this advice regarding outcome measures to use and how best to administer in clinical practice. - A reflective element of the group and individual sessions would be informative, and we will consider how to implement this.
To improve clinical utility: - Completing outcome measures in 1:1 MBT sessions could enhance opportunities to use them to reflect on progress and facilitate the use of more individually tailored measures (e.g. idiosyncratic goal ratings) to make them more meaningful for clients. This may also enhance response rates by increasing client investment and motivation to track these changes.	- The service will move to completing measures in the individual sessions to make them potentially more meaningful in line with these recommendations.
To improve validity and address anonymity concerns: - Feedback data quantity, honesty and depth may be improved by seeking feedback once people complete the programme to reduce concerns about possible impact on care from comments being identifiable. - As less responses were provided to questions about possible improvements, interviews may be beneficial to further explore this or understand any additional barriers to providing constructive feedback. - Explicitly remind people in group or at assessment that their feedback about the group will not impact negatively on their care. - Consider how to make the feedback process less identifiable, particularly if small group numbers continue. For example, by providing an anonymous suggestions box separate from outcome measure completion in reception or via an online survey link.	- When the service is more established interviews would be a helpful source of feedback. - Setting up a separate box for feedback that is held in reception is definitely feasible to try and reduce anonymity concerns.

Resourcing Recommendations	Summary of Service Response
- Consider feasibility of offering the MBT programme in this service and seek support for duty line protected time and funding for staff training to sustain quality if it continues.	- The service agrees that protected time and staff training are imperative to sustain a quality service particularly for labour-intensive services such as MBT. - This recommendation will be fed back to managers to support this request.
To optimise staffing levels: - Explore whether there is flexibility for Older Adult (OA) focused therapist to take on working age adult/s (WAA) or facilitate the group, and if not (and OA referral rates remain low) prioritise training for professionals working with WAAs in line with demand. - When selecting staff for training, emphasise the 18-month length of the programme and the value to SUs of building a strong therapeutic relationship with one person.	- An OA therapist now co-facilitates the weekly MBT group. This has been agreed with the OA manager. - Staff retention is an issue across the team and has affected the viability of delivering other therapeutic modalities (MBT and DBT).
Uptake, Engagement and Retention Recommendations	**Summary of Service Response**
- Consider additional follow-up phone calls to drop-outs a month to increase retention rates (with a focus on providing an opportunity to reflect and check in on wellbeing rather than actively advocating returning to MBT).	- This should happen as part of a standard discharge plan, but it would be helpful to feedback to the MBT service to ensure this is happening.
- Offering bitesize training about MBT and personality disorder for the older adult teams may enhance referrals from this population. This may also enhance this group's engagement if their care co-ordinators are able to advocate for MBT's possible benefits. Training for other services could also be considered to increase referrals generally.	- Our OA therapists have done this, but we will consider doing this on a regular basis. Providing training to other services including the primary care liaison service to ensure people are aware of MBT and what referrals might be appropriate will also be explored.
- If resourcing can be improved, aim to increase number of full MBT group members to enhance SU experience (based on requests from participants for more members). This may be achieved by reviewing assessment criteria for full MBT, in light of over 50% not being considered appropriate for further MBT following MBTi, and the proportion progressing decreasing over time.	- The service is aiming to do this, however lack of individual therapists trained to provide the one to one element of the programme have restricted growth.
Group Recommendations	**Summary of Service Response**
- Regular checking in of understanding of what mentalising is and revision of relevant psychoeducation as needed.	- This is part of the model and we will incorporate this in the programme more actively going forward based.

- Agree a protocol for whether welfare checks are offered if SUs do not attend group sessions.	- Our protocol is being reviewed and this is a helpful suggestion to ensure we include welfare checks within this.
- Remind people at the beginning of groups that is it a non-judgmental space and encouraging them to share/check out any concerns about other's responses to them so they can be thought about and addressed together.	- Ground rules are discussed in the group but based on this feedback revisiting this more often in the group might help to cultivate a more trusting mentalising culture.
- Discuss with group how the therapists (and group) could help people contribute more in the group, as many people highlighted talking openly and asking questions as valuable but challenging at times. - As some people noted feeling more able to talk openly in 1:1 sessions, individual therapists to discuss with them what might help them make more use of the group (as many commented on the value of contributing to the group and helping others).	- This reflects feedback from reviewing video recordings of the group in supervision and is something we have begun to actively encourage and facilitate. - This is explicit in the model and in line with best practice guidelines for MBT but something that is helpful to clarify on an ongoing basis to ensure we are adhering to protocol.
Duty Line Recommendations	**Summary of Service Response**
To improve accessibility: - Ensure administration and reception staff know what MBT is, who the MBT team members are and how to contact the duty staff member. - To improve consistency and predictability: - If resources remain unchanged it may be beneficial to manage SU expectations of the duty line by providing a timetable of when this will be available, potentially with more limited hours. - Consider feasibility of timetable including allocated duty therapist name. - Agree a timeframe for SUs to receive a call back may be beneficial to manage expectations.	- In response to this feedback the protocol for the duty line will be reviewed both within the service and with admin staff to ensure it is as effective and user friendly as possible.
To address confidentiality concerns: - Gaining clear consent regarding what can be shared by therapists in the group may increase people's use and honesty on duty line calls.	- This has come up before in the group and this recommendation gives us more explicit feedback to inform our ground rules and protocols.

Limitations

This project was initially designed to evaluate ways of measuring outcome in MBT in a routine NHS setting, with secondary aims of assessing efficacy and SU experience, to inform suggestions to optimise the intervention without overdelivering. Due to unforeseen service changes and limited MBT programme utilisation the project aims necessarily changed part-way through; so the method was not originally designed to address these revised questions. The pressure to demonstrate quantifiable outcomes for commissioners influenced the initial research questions requested by the service, potentially limiting the original scoping and focus of the study.

Collecting feedback using questionnaires prevented follow-up on pertinent comments as would have been afforded by semi-structured interviews. Nonetheless, engagement with interviews may still have been problematic considering SU comments that they felt unable to give honest feedback due to anonymity concerns. It may have more fruitful to interview SUs for feedback after treatment completion, however this was not possible within the project's timescale. The lack of drop-out interview uptake produces potential for bias, as no perspectives of people who presumably found the programme less helpful than those who continued are represented. Conclusions and generalisability are limited by the small sample size, and the risk of privileging the views of the first cohort over the second since they had more opportunities to provide feedback over the 12-month project.

Recommendations for future quality improvement projects

This project originally aimed to examine if and when change occurred during the newly offered full MBT programme within a local NHS service. As outlined in the limitations section above, the limited data meant it was not feasible to answer these initial research questions. This was due to lower than expected uptake and retention with the MBT programme and poor rates of outcome measure completion. Participant numbers were also negatively impacted by staff attrition which appeared to limit service provision.

To overcome the limitations and feasibility issues apparent within this study, it is recommended that future quality improvement projects for this service consider interviewing SUs who have completed the full MBT programme. These interviews could be used to gain further detailed feedback regarding their experience of the programme to

inform improvements as they would be less restricted by the concerns about anonymity and subsequent potential impact on care expressed by this study's participants whilst currently receiving treatment. People who have completed the programme could also be asked about their experience of change and how this could be meaningfully and feasibly captured to inform potential alternative methodologies to address the original project aims. Interviewing MBT staff about these topics may also be fruitful to guide future approaches to evaluating effectiveness. This project utilised self-report measures as requested by the service, aiming for sustainability and efficiency. However as this was unsuccessful, alternatives such as collecting more idiosyncratic outcome measures in individual sessions as suggested above or using measures completed via clinical interviews, such as the Zanarini Rating Scale (Zanarini, 2003), could be considered. Analysing data on service utilisation using clinical notes as employed by Bateman and Fonagy (2001) may hold merit in providing information about potential financial benefits for commissioners and indicating occurrences of risk-related behaviours.

Conclusions

This study highlights the importance of services providing adequate resourcing for MBT to ensure model fidelity, and the potential impact on SU experience if this is not possible. Furthermore, it demonstrates the challenges of engaging people with BPD and measuring outcomes for this group within MBT, suggesting capturing outcomes weekly is potentially unfeasible in this longer-term intervention. Those who received full MBT and stayed in the programme appeared to find value in the programme: they had good attendance rates and reported finding aspects of the group useful, particularly when they and others contributed more despite this being challenging at times.

References

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5). Washington: American Psychiatric Association.

Bateman, A., Bales, D. & Hutsebaut, J. (2018). *Quality manual for MBT*. Anna-Freud Centre. Retrieved from: https://www.annafreud.org/media/7863/quality-manual-2018.pdf

Badoud, D., Prada, P., Nicastro, R., Germond, C., Luyten, P., Perroud, N., & Debbané, M. (2017). Attachment and Reflective Functioning in Women With Borderline Personality Disorder. *Journal of Personality Disorders*, 1-14. doi:10.1521/pedi_2017_31_283

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. John Wiley & Sons.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American journal of Psychiatry, 156*(10), 1563-1569.

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American journal of psychiatry, 158*(1), 36-42.

Bateman, A., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165*(5), 631-638.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry, 166*(12), 1355-1364.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry, 9*(1), 11-15. doi:10.1002/j.2051-5545.2010.tb00255.x

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.

Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal behavior in borderline personality disorder: prevalence, risk factors, prediction, and prevention. *Journal of personality disorders, 18* (3), 226-239.

Blum, N., Pfohl, B., John, D. S., Monahan, P., & Black, D. W. (2002). STEPPS: A cognitive-behavioral systems-based group treatment for outpatients with borderline personality disorder—a preliminary report. *Comprehensive Psychiatry, 43*(4), 301-310. doi:https://doi.org/10.1053/comp.2002.33497

Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R.-D., Domsalla, M., Chapman, A. L., . . . Wolf, M. (2009). The short version of the Borderline Symptom List (BSL-23): development and initial data on psychometric properties. *Psychopathology, 42*(1), 32-39.

Coid, J., Yang, M., Bebbington, P., Moran, P., Brugha, T., Jenkins, R., . . . Ullrich, S. (2009). Borderline personality disorder: health service use and social functioning among a national household population. *Psychological medicine, 39*(10), 1721-1731.

Connell, J., Barkham, M., Stiles, W., Twigg, E., Singleton, N., Evans, O., & Miles, J. (2006). Distribution of CORE–OM scores in a general population, clinical cut-off points and comparison with the CIS–R. *The British Journal of Psychiatry, 190*(1), 69-74.

Cucchi, A., Hampton, J. A., & Moulton-Perkins, A. (2018). Using the validated Reflective Functioning Questionnaire to investigate mentalizing in individuals presenting with eating disorders with and without self-harm. *PeerJ, 6*, e5756.

Dyson, H., & Brown, D. (2016). The experience of mentalization-based treatment: an interpretative phenomenological study. *Issues in mental health nursing, 37*(8), 586-595.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing, 62*(1), 107-115.

Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE–OM. *The British Journal of Psychiatry, 180*(1), 51-60.

Fonagy, P., & Bateman, A. W. (2007). Mentalizing and borderline personality disorder. *Journal of Mental Health, 16*(1), 83-101. doi:10.1080/09638230601182045

Fonagy, P., Luyten, P., Moulton-Perkins, A., Lee, Y.-W., Warren, F., Howard, S., . . . Lowyck, B. (2016). Development and validation of a self-report measure of mentalizing: The reflective functioning questionnaire. *PloS One, 11*(7), e0158678.

Glenn, C. R., & Klonsky, E. D. (2009). Emotion dysregulation as a core feature of borderline personality disorder. *Journal of personality disorders, 23*(1), 20-28.

Johnson, E. L., Mutti, M.-F., Springham, N., & Xenophontes, I. (2016). Mentalizing after mentalization based treatment. *Mental Health and Social Inclusion, 20*(1), 44-51.

Keown, P., Holloway, F., & Kuipers, E. (2002). The prevalence of personality disorders, psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. *Social Psychiatry and Psychiatric Epidemiology, 37*(5), 225-229. doi:10.1007/s00127-002-0533-z

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology, 17*(4), 959-986.

Lonargáin, D. Ó., Hodge, S., & Line, R. (2017). Service user experiences of mentalisation-based treatment for borderline personality disorder. *Mental Health Review Journal, 22*(1), 16-27.

Malda-Castillo, J., Browne, C., & Perez-Algorta, G. (2018). Mentalization-based treatment and its evidence-base status: A systematic literature review. *Psychology and Psychotherapy: Theory, Research and Practice*.

MIND. (2013). *We still need to talk. A report on access to talking therapies.* Retrieved from https:// www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

Morken, K. T. E., Binder, P. E., Arefjord, N., & Karterud, S. (2019). Juggling thoughts and feelings: How do female patients with borderline symptomology and substance use disorder experience change in mentalization-based treatment? *Psychotherapy Research, 29*(2), 251-266. doi:10.1080/10503307.2017.1325021

Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *The British Journal of Psychiatry, 180*(5), 461.

National Institute for Clinical Excellence. (2009). *Borderline personality disorder: recognition and management. NICE; London.*

Pfohl, B., Blum, N., St. John, D., McCormick, B., Allen, J., & Black, D. W. (2009). Reliability and validity of the borderline evaluation of severity over time (BEST): A self rated scale to measure severity and change in persons with borderline personality disorder. *Journal of personality disorders, 23*(3), 281-293. doi:10.1521/pedi.2009.23.3.281

Smits, M. L., Feenstra, D. J., Eeren, H. V., Bales, D. L., Laurenssen, E. M. P., Blankers, M., . . . Verheul, R. (2019). Day hospital versus intensive out-patient mentalisation-based treatment for borderline personality disorder: multicentre randomised clinical trial. *The British Journal of Psychiatry*, 1-6.

Soloff, P. H., Lis, J. A., Kelly, T., Cornelius, J., & Ulrich, R. (1994). Self-mutilation and suicidal behavior in borderline personality disorder. *Journal of Personality Disorders, 8*(4), 257-267.

Stoffers, J. M., Völlm, B. A., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*(8). doi:10.1002/14651858.CD005652.pub2

Vogt, K. S., & Norman, P. (2018). Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. *Psychology and Psychotherapy: Theory, Research and Practice*.

Youn, S. J., Kraus, D. R., & Castonguay, L. G. (2012). The treatment outcome package: Facilitating practice and clinically relevant research. *Psychotherapy, 49*(2), 115.

Zanarini, M. C. (2003). Zanarini Rating Scale For Borderline Personality Disorder (ZAN-BPD): A Continuous Measure of DSM-IV Borderline Psychopathology. *Journal of Personality Disorders, 17*(3), 233-242. doi:10.1521/pedi.17.3.233.22147

Main Research Project

Negative Interpretations of Ambiguous 'Psychosis-like' and 'Anxiety-like' Experiences in Recovery from Psychosis or Anxiety: An Exploratory Study

Rebecca Sired

Doctorate in Clinical Psychology

Department of Psychology, University of Bath, Claverton Down

Bath, BA2 7AY

r.sired@bath.ac.uk

June 2019

Word count: 5248 words

Internal Supervisors: Dr Emma Griffith, Clinical Tutor and Lecturer, Doctorate in Clinical Psychology Programme, Department of Psychology, University of Bath, E.J.Griffith@bath.ac.uk

Professor Paul Salkovskis, Honorary Professor, Doctorate in Clinical Psychology Programme, Department of Psychology, University of Bath, paul.salkovskis@hmc.ox.ac.uk

External Supervisors: Dr Taruna Jamalamadaka, Clinical Psychologist, Avon and Wiltshire Mental Health Partnership NHS Trust, t.jamalamadaka@nhs.net

Proposed Journal for Publication: British Journal of Clinical Psychology, selected as it publishes empirical and theoretical research on all areas of clinical psychology (see Appendix K)

Abstract

Objectives: Fear of relapse (FOR) after experiencing psychosis has been found to predict actual relapse (Gumley et al., 2015); however potential mechanisms underlying this relationship have not been investigated. Negative appraisals are believed to play a crucial role in both psychosis and mental health anxiety (MHA). This study aimed to explore whether people in recovery from psychosis or anxiety negatively interpret ambiguous experiences related to their previous mental health difficulty relative to controls.
Design: A cross-sectional between-groups questionnaire design.
Methods: Participants in recovery from psychosis (n=33) or anxiety (n=77) or with no previous mental health experience (n=61) were recruited online or via NHS services. Interpretations of psychosis-like, anxiety-like and external-control experiences were measured using the Experiences Interpretation Questionnaire (EIQ) developed for this purpose, and MHA and FOR using self-report questionnaires. A two-way (group x item type) mixed-model ANOVA was used to test for interactions and between group differences in negative interpretations. Linear regression modelling was used to examine associations between independent variable, MHA (and FOR as covariate) and dependent variable, negative interpretations. A t-test was used to compare differences in mean FOR between the MH groups.
Results: People in recovery from psychosis interpreted psychosis-like experiences significantly more negatively than the other groups. Negative interpretations of anxiety-like experiences were comparable for the mental health groups, both differing significantly from controls. Contrary to predictions, FOR was not significantly different between the mental health groups. MHA and FOR did not significantly predict negative interpretations of psychosis-like items in the psychosis group, however MHA predicted negative interpretations of anxiety-like items in the anxiety group. The EIQ subscales demonstrated good test-retest reliability.
Conclusions: Findings suggest people in recovery from psychosis or anxiety may negatively interpret ambiguous experiences relating to their previous mental health difficulties. Interpretations of possible symptoms may merit attention during relapse prevention planning and further research exploring relationship with relapse may be of value.

Keywords: Psychosis, Anxiety, Interpretation, Fear of Relapse, Mental Health Anxiety

Introduction

The British Psychological Society's report 'Understanding Psychosis' (2014) states psychosis is characterised by experiences such as hearing or feeling things others do not (hallucinations) and holding strong beliefs not shared by others (delusions). Psychosis is related to significant changes in thoughts, perceptions, mood and behaviours (NICE, 2014) and most frequently associated with diagnoses such as schizophrenia, delusional disorder, bipolar disorder and schizoaffective disorder (Royal College of Psychiatrists, 2015). A UK survey reported a 0.5% prevalence rate for probable psychosis in 16 to 74-year olds (Singleton, Bumpstead, O'Brien, Lee & Meltzer, 2003), with marked heterogeneity in rates across studies and demographics (Kirkbride et al., 2012).

Reavley, Morgan and Jorm (2017) found disclosure of a diagnosis of psychosis significantly predicted avoidance by others and discrimination. The label "schizophrenia" is associated with negative stigma and frequently linked to violence in UK media (Bowen, Kinderman & Cooke, 2019). This diagnosis is connected with many negative effects including a 2-3 times higher mortality risk (Brown, Kim, Mitchell & Inskip, 2010) and more negative stereotypes and lower expectations of recovery comparative to depression or anxiety (Wood, Birtel, Alsawy, Pyle & Morrison, 2014).

Despite improved remission and recovery rates after experiencing psychosis (Lally et al, 2017), relapse remains common. Following a first episode up to 54% of individuals relapse within three years (Alvarez-Jimenez et al., 2012) and up to 80% within five years (Robinson et al., 1999). Relapse has been associated with an increased risk of chronicity, depression and suicidal ideation (Birchwood, Iqbal, Chadwick & Trower, 2000) and high costs to services (Almond, Knapp, Francois, Toumi & Brugha, 2004). There is currently no conclusive evidence that cognitive behavioural therapy (CBT) reduces relapse rates (Alvarez-Jiménez, Parker, Hetrick, McGorry & Gleeson, 2009; Garety et al., 2008) unless specifically relapse focused (Tarrier & Wykes,, 2004) and early signs monitoring has only moderate predictive value (Eisner, Drake & Barrowclough, 2013). Traditional psychiatric models of psychosis emphasise insight development as key for recovery, however this idea is challenged by those viewing insight as complex and multi-faceted (Amador & David, 2004; Sparrowhawk, 2009) and findings that having alternative explanations for delusions is associated with lower self-esteem (Freeman et al., 2004). Further research to aid the development of interventions to prevent relapse is therefore required (Eisner et al., 2013).

Fear of Relapse

Following an episode of physical ill health, people can become anxious about the possibility of this reoccurring (Ozga et al., 2015). The impact of this fear of recurrence on psychological distress, functioning (Lee-Jones, Humphris, Dixon & Bebbington, 1997; Simard, Savard & Ivers, 2010) and quality of life (Koch et al., 2014) is well established in cancer survivors (Simonelli, Siegel & Duffy, 2017).

Increased fear of illness recurrence (also called fear of relapse; FOR) has been found to be a significant predictor of post-psychotic post-traumatic stress disorder (PTSD) (White & Gumley, 2009). A randomised controlled trial found greater FOR was associated with shorter time to actual relapse in psychosis, and better predicted relapse relative to early signs monitoring (Gumley et al., 2015). The authors concluded FOR may be related to poorer emotional recovery and greater relapse risk (Gumley et al., 2015); which has yet to be explored in other mental health (MH) conditions.

A cross-sectional study by Jamalamadaka (2017) found people in recovery from psychosis reported significantly greater FOR than those who had experienced MH difficulties without psychosis. The authors noted that the comparison group also had high levels of FOR. One limitation of this study is that the psychosis group rated themselves as significantly more recovered than the other MH group, which may be a confound to the finding of higher FOR. Mental health anxiety was a significant predictor of FOR irrespective of group and higher in both MH groups comparative to those with no previous MH problems (Jamalamadaka, 2017).

Cognitive Models of Psychosis

People make sense of their experiences via appraisals, which are central to cognitive models of psychosis (such as Morrison; 2002, and Garety, Kuipers, Fowler, Freeman and Bebbington, 2001). These draw on cognitive models of anxiety, such as the panic model by Clark (1986). Morrison (2002) suggests the interpretation of anomalous experiences, such as voices, as physically or psychologically threatening increases negative emotions (including anxiety and depression) and physiological arousal, rather than the experience itself. In turn, these negative emotions and increased physiological arousal are proposed to lead to an increase in unusual experiences, creating a vicious cycle. These misinterpretations understandably lead the person to try and keep

themselves safe from the perceived threat through behaviours such as hypervigilance. Such safety-seeking strategies inadvertently prevent disconfirmation of misinterpretations and often increase the occurrence of the anomalous experiences, thus reinforcing the belief they are under threat.

Evidence for the role of appraisals in distress from hallucinations (Birchwood, 2003) and delusions is established (Kuipers et al., 2006). Studies with people at risk of psychosis (Taylor, Parker, Mansell & Morrison, 2013) and comparing clinical and non-clinical populations with psychotic-like experiences (Brett, Heriot-Maitland, McGuire & Peters, 2014) support the relationship between appraisals of anomalous experiences and distress. A longitudinal study of people in recovery found perceptions of negative consequences of psychosis, but not objective symptom severity, were associated with poorer quality of life (Stainsby, Sapochnik, Bledin & Mason, 2010). The authors therefore posit people's beliefs about their difficulties are key in quality of life in recovery, rather than quantifiable symptomatology. Negative illness perceptions about psychosis are also associated with low self-esteem, depression and anxiety; factors which have been linked to recurrence (Watson et al., 2006).

Mental Health Anxiety

The cognitive behavioural model of health anxiety (Salkovskis & Warwick, 1986) suggests when anxious about their health, people more frequently catastrophise possible symptoms and consider them indicative of a serious illness, thus increasing their anxiety. Rachman (2012) posits that fears often pertain to illnesses associated with distressing personal experience (Warwick, 1989), and people can have similar concerns about mental health problems.

In relation to psychosis, higher levels of worry, anxiety and fear of madness were found in those experiencing delusions comparative to clinical controls, with fear of madness associated with higher persecutory delusional distress (Bassett, Sperlinger & Freeman, 2009). A systematic review found anxiety to be associated with severity of psychosis symptoms, sub-clinical experiences of psychosis, prognosis and relapse (Hartley, Barrowclough & Haddock, 2013). Worry has also been found to predict paranoid thinking, and interventions targeting worry have been demonstrated to reduce persecutory delusions (Freeman et al., 2015). These findings support the role of anxiety in psychosis,

and the proposition that anxiety about symptoms may worsen symptoms creating a vicious cycle.

Catastrophic misinterpretation involves “perceiving sensations as much more dangerous than they really are” (Clark, 1986, p.462). Applied to those in recovery, it is therefore suggested that interpreting possible signs of relapse specific to their previous experience of MH difficulties as more threatening (as catastrophic) than they actually are may lead to increased anxiety and arousal, and subsequently increase symptoms leading to relapse.

Gumley’s (2006) trauma-based model of psychosis relapse proposes excessively negative appraisals of relapse play a key role. Considering the threat value of psychosis based upon its distressing nature and aforementioned negative impacts, potential signs of relapse are likely to be appraised as catastrophic. Gumley (2006) suggests people may perceive changes in their experiences (e.g. thoughts, perceptions) as evidence of losing control, associating them with previous psychotic experiences and thus increasing feelings of threat and anxiety. Similarly, Birchwood and Spencer (2001) have theorised that reacting to mild psychotic experiences by appraising relapse as catastrophic is likely to be associated with increased tendency for actual relapse. The main aim of the study was to explore whether people in recovery from psychosis or anxiety interpret possible symptoms of their previous mental health problem more negatively than people without prior experience of mental health problems.

Hypotheses

Primary hypotheses:

- People in recovery from psychosis will be more likely to negatively interpret psychosis-like experiences as meaning their mental health is getting worse than people in recovery from anxiety and healthy controls.
- Similarly, those in recovery from anxiety disorders will significantly more likely to negatively interpret anxiety-like experiences.
- There will be no difference between groups for external-control items.

Secondary hypotheses:

- People with experience of psychosis will have significantly higher FOR than people with experience of anxiety disorders.
- FOR and MHA will predict negative interpretations of possible symptoms related to their previous MH difficulty (psychosis or anxiety for the respective groups).

Method

Design

A cross-sectional between-groups questionnaire design was used, drawing on methodology from Jamalamadaka (2017) and Clark et al. (1997) both of which utilised between-groups questionnaire designs. The current study utilised the secondary measures and definition of recovery employed within Jamalamadaka's (2017) unpublished thesis to enable replication of its primary finding as a secondary aim. An adapted version of the primary outcome measure of Clark et al. (1997) was utilised by this study as both projects aimed to investigate catastrophic interpretations of ambiguous experiences within MH populations. The independent variables were self-defined previous main MH problem (psychosis, anxiety or no MH difficulties) and item type (EIQ subscales: psychosis-symptoms, anxiety-symptoms and external-control items) and the primary dependent variable was mean total score for negative interpretations per item type.

Participants

Participants were recruited online via social media sites such as Twitter and Facebook, 'Call for participants', MH and charity websites and through recovery, Early Intervention in Psychosis (EIP), and primary care services at Avon and Wiltshire Partnership Mental Health Foundation Trust and 2gether NHS Foundation Trust. Posters, word of mouth and the University of Bath website were also used.

One hundred and seventy-one participants were recruited: 33 people in recovery from psychosis, 77 people in recovery from an anxiety disorder and 61 non-clinical controls. Part two was completed by 32 participants: six in recovery from psychosis, 17 in recovery from anxiety and nine controls.

Table 3.1

Inclusion and exclusion criteria for groups

	Inclusion Criteria	**Exclusion Criteria**
Mental health groups	Aged 18 or over Self-reported experience of psychosis as their main MH problem for which they received a diagnosis or treatment OR Self-reported experience of an anxiety disorder (Obsessive-Compulsive Disorder, Panic Disorder with or without agoraphobia, Generalised Anxiety Disorder or Social Anxiety Disorder) as their main MH problem for which they received a diagnosis or treatment AND, consider themselves to be in recovery	Self-reported Health Anxiety, Substance Use Disorder or Learning Disability
Non-clinical control group	Aged 18 or over No self-reported experience of a MH problem for which they received a diagnosis or treatment	Self-reported Health Anxiety, Substance Use Disorder or Learning Disability

Recovery Definition and Screening

In line with Jamalamadaka (2017), this study used the recovery definition provided by the South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010, p. 4):

"Recovery does not necessarily mean 'clinical recovery' (usually defined in terms of symptoms and cure) - it does mean 'social recovery' – building a life beyond illness without necessarily achieving the elimination of the symptoms of illness. Recovery is often described as a journey, with its inevitable ups and downs and people often describe themselves as being 'in recovery' rather than 'recovered'."

Recovery was therefore measured as a continuous variable based upon each persons' perception of their progress, rather than as a categorical, symptomatic approach. This is consistent with views of recovery as a personal journey rather than being dualistic and diagnostic based (Lloyd, Waghorn & Williams, 2008; Slade, 2009; Slade & Longden, 2015). Thus, the screening question used by Jamalamadaka (2017) was also employed by this study: "Would you say you have been able to build a life beyond your main mental health problem (even if all your symptoms haven't disappeared)?". Responses were given on a 9-point Likert scale from 1 (Strongly disagree) to 9 (Strongly agree). Participants

answering “mildly disagree”, “moderately disagree”, “disagree” or “strongly disagree” were excluded.

Measures

Demographics and Mental Health History. Data was collected about participants age, gender, ethnicity, relationship status, employment and education. Information regarding participants’ MH experience was also gathered, including their main diagnosis, number of episodes, treatment, any secondary diagnoses, ratings of recovery and current severity of symptoms compared to their worst.

Experiences Interpretation Questionnaire (EIQ). A 24-item questionnaire developed for this study to measure negative interpretations of ambiguous possible MH symptoms. The EIQ is based on the 27-item Bodily Sensations Interpretation Questionnaire (BSIQ; Clark et al., 1997), which has been previously adapted (Gardner, Salkovskis & Walker, 2015) and has established validity (Clark et al., 1997) and satisfactory-to-good internal consistency across the four subscales (Cronbach’s α =0.73 to 0.86; Vancleef & Peters, 2008). The EIQ has three subscales with eight items each: psychosis-like experiences, anxiety-like experiences and external-control items. MH items were based on the DSM 5 (APA., 2013) diagnostic criteria for the relevant disorders. External-control items were included to check for participants responding more negatively generally and excluded interpersonal situations due to potential overlap with paranoia or social anxiety. Respondents were asked to write free-text the first explanation that came to mind, and on the following page rank from 1(most likely) to 4(least likely) four given explanations (one negative, two neutral/normalising and one positive). Question order by subscale and explanation responses were randomised throughout the questionnaire.

In line with the BSIQ, scores were calculated based on the negative explanation’s rank order; if ranked first this scored 4, second scored 3, third 2 and fourth 1, and scores summed per subscale. Clark et al. (1997) reported time-intensive analysis of open-ended responses did not contribute significant further information to rank data. Adhering to advice by Clark et al. (1997), these were not analysed and included primarily to prompt participants to consider their initial response before options were presented.

Mental Health Anxiety. The mental health anxiety inventory (MHAI; Commons, Greenwood & Anderson, 2016) is an 18-item questionnaire with two subscales: 14-item

MHAI and 4-item perceived awfulness. It has good construct validity and internal reliability (Cronbach's α =0.92). Scores range from 0-42 (0-3 per item), with higher total scores signifying greater MHA and a clinical cut-off of 27. Where more than one item was endorsed, the highest score was used (Salkovskis, Rimes, Warwick & Clark, 2002).

Fear of Relapse. The Fear of Recurrence Scale (FORSE; Gumley, 2013) is a 23-item measure of FOR developed for psychosis, with excellent internal reliability (Cronbach's α =0.92) and good test-retest reliability (*r* =.70) (Gumley et al., 2015). Total scores range from 23-92 (1-4 per item), with larger scores indicating higher fear of relapse.

Quality of Life in Recovery. The 10-item validated Recovering Quality of Life measure (ReQoL; Keetharuth et al., 2017) of MH recovery focused quality of life, which has acceptable internal consistency (Cronbach's α =0.92), test-retest reliability (*r* =.85) and convergent validity.

Functioning and Severity. The Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear, & Greist, 2002) is a 5-item scale with good psychometric properties measuring functioning in the following domains: work, home management, social and private leisure activities and relationships. Participants completed this measure twice; once relating to current functioning and once for when their main MH problem was at its worst (to provide information about severity based on functional impact). Participants also rated the severity of current symptoms of their main MH problem comparative to the worst they have been on a 7-point Likert scale ranging from 1(No symptoms) to 7(Extremely severe).

Depression. The PHQ-9 is a reliable and valid 9-item measure of depression (Kroenke, Spitzer, & Williams, 2001), with higher scores indicating increased severity ranging from 0-27.

Anxiety. The GAD-7 is a 7-item measure of anxiety symptoms (Spitzer, Kroenke, Williams, & Löwe, 2006) reporting good psychometric properties. Ranging from 0-21, higher scores indicate more severe anxiety symptoms.

Involvement of People with Personal Experience (PPE)

Two people with personal experience of psychosis and one of anxiety were consulted regarding the project's usefulness, design and acceptability. They also assisted with the development of the EIQ questionnaire; designing and giving feedback on items,

layout and wording. Another PPE reviewed and piloted the additional study materials. PPE's were reimbursed £10 vouchers/hour for their time.

Procedure

Ethical approval was obtained from the NHS Health Research Authority (ref: 18/SC/0522; Appendix L), the University of Bath Psychology Ethics Committee (ref: PREC 18-306; Appendix M) and the Research and Development teams of the relevant NHS Trusts (Appendix N).

Clinicians gave potential NHS participants an information sheet regarding the study with research team contact details for questions. All participants could take part online or by post via a pre-paid envelope. After reading the information sheet, participants read and completed a consent form and completed an eligibility screening phase which included an automated computerised bot test. Participants then provided demographic and MH information and completed the questionnaires. Upon completion, participants viewed the debrief sheet explaining the study rationale and signposting to sources of support and research team contact details to request further information and study findings. Participants were invited to have a £2 MH charity donation made on their behalf; no other incentives were provided. Two weeks later, those who opted-in online to part 2 completed another consent form, provided their unique codeword (anonymously linking their data sets), completed the EIQ again and viewed a debrief sheet.

Statistical Analysis

Power Considerations. An a priori power calculation using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) indicated a minimum sample size of 159 (53 per group) was required for 80% power to detect differences between the three groups at 0.05 two-tailed significance level, with a medium effect size of f=0.25 (as per categorisation by Cohen, 1988). f is the effect size used by G*Power and deemed appropriate for this study due to using ANOVA to test for differences between means of three groups (Ialango, 2016). Clark et al. (1997) reported a large effect size, Cohen's d = 1 (as per categorisation by Cohen, 1988), using a similar between-groups design to this research and the original BSIQ questionnaire which this study's primary measure was adapted from. A medium effect size was therefore selected to be conservative/cautious due to this study's exploratory nature in using a newly adapted measure and different population.

Analysis. Data was analysed using IBM SPSS v24 according to the *a priori* data analytic plan. Categorical and continuous group characteristics were considered per group using totals and percentages, and means and standard deviations respectively. A two-way (independent variables: group x item type) mixed model ANOVA was used for primary hypothesis testing with the dependent variable mean negative interpretations. Significant interactions were examined using one-way independent measures ANOVAs and a priori contrasts for main effects of group by subscale. Least Significant Difference (LSD) was reported, or Dunnett's T3 if Levene's test indicated issues in equality of variance. An independent samples t-test was used to investigate differences in FOR between MH groups. Two linear hierarchical regression analyses were used to test whether MHA (independent variable) and FOR (co-variate) predicted negative interpretations of possible-symptoms related to previous MH difficulty (dependent variable); one per MH group. The EIQ's test-retest reliability was explored using Pearson's correlation co-efficient.

Results

Participants

Of the 244 respondents, 171 met the studies inclusion criteria. 54 were screened out as their main MH problem was not psychosis or an included anxiety disorder (OCD, GAD, panic disorder, SAD). Fourteen people with psychosis experience and five with anxiety experience were considered not sufficiently recovered in line with the pre-specified criteria. One participant completed paper questionnaires; this data was excluded as a lack of information concerning MH experience prevented group allocation. Of the 171 included in the study, six participants were recruited from MH services.

Table 3.2

Self-reported main diagnosis for mental health groups

Group	Self-reported diagnosis	Number (%)
Psychosis	Schizophrenia	8 (24.2)
	First episode psychosis	6 (18.2)
	Bipolar with psychotic features	4 (12.1)
	Schizoaffective disorder	4 (12.1)
	Psychotic depression	3 (9.1)
	Delusional disorder	2 (6.1)
	Brief psychotic disorder	2 (6.1)

	Other	4 (12.1)
	Total	33/33 (100)
Anxiety	Generalised Anxiety Disorder (GAD)	47 (63.5)
	Panic disorder (with or without agoraphobia)	11 (14.9)
	Social anxiety/social phobia	8 (10.8)
	Obsessive-Compulsive Disorder (OCD)	8 (10.8)
	Total	74/77 (96)

Categorical Group Characteristics

Table 3.3 shows categorical group characteristics for each group and for the total sample. Due to outliers and missing data, number of episodes of main MH problem was categorised for comparison. The overall sample was mostly female and Caucasian.

There appeared to be no notable differences between the groups except for employment and relationship status. A higher proportion of the anxiety and control groups were in paid employment than the psychosis group. The psychosis group had more participants who were single than the other two groups.

Table 3.3

Categorical characteristics of participants by group

Group	**Recovery from psychosis**	**Recovery from anxiety**	**Control**	**Total (all participants)**
	Number (%)	*Number (%)*	*Number (%)*	*Number (%)*
n	33	77	61	171
Gender				
Male	7 (21.2)	12 (15.6)	16 (26.2)	35 (20.5)
Female	24 (72.7)	64 (83.1)	45 (73.8)	133 (77.8)
Gender non-conforming	1 (3)	1 (1.3)	0	2 (1.2)
Prefer not to say	1 (3)	0	0	1 (0.6)
Educational level				
No formal education	-	-	-	-
Primary	-	-	-	-
Secondary (GCSE's/O-levels)	2 (6.1)	1 (1.3)	2 (3.3)	5 (2.9)
A-levels	3 (9.1)	7 (9.1)	5 (8.2)	15 (8.8)
Diploma or professional qualification	6 (18.2)	3 (3.9)	4 (6.6)	13 (7.6)
Undergraduate degree	10 (30.3)	27 (35.1)	19 (31.1)	56 (32.7)
Postgraduate degree	11 (33.3)	34 (44.2)	19 (31.1)	64 (37.4)
PhD	1 (3)	5 (6.5)	10 (16.4)	16 (9.4)
Prefer not to say	-	-	-	-

Other	-	-	2 (3.3)	2 (1.2)
Relationship status				
Single	15 (45.5)	17 (22.1)	11 (18)	43 (25.1)
In a relationship	6 (18.2)	24 (31.2)	16 (26.2)	46 (26.9)
Co-habiting	1 (3)	13 (16.9)	14 (23)	28 (16.4)
Married	10 (30.3)	21 (27.3)	17 (27.9)	48 (28.1)
Divorced	1 (3)	2 (2.6)	3 (4.9)	6 (3.5)
Widowed	-	-	-	-
Prefer not to say	-	-	-	-
Other	-	-	-	-
Ethnicity				
Asian	2 (6.1)	2 (2.6)	3 (4.9)	7 (4.1)
Black	2 (6.1)	-	2 (3.3)	4 (2.3)
Caucasian	27 (81.8)	69 (89.6)	53 (86.9)	149 (87.1)
Mixed background	2 (6.1)	6 (7.8)	2 (3.3)	10 (5.8)
Prefer not to say	-	-	1 (1.6)	1 (0.65)
Other	-	-	-	-
Employment status				
Paid employment	18 (54.5)	58 (75.3)	51 (83.6)	127 (74.3)
Student	11 (33.3)	19 (24.7)	7 (11.5)	37 (21.6)
Voluntary work	1 (3)	3 (3.9)	2 (3.3)	6 (3.5)
Sick leave	2 (6)	4 (5.2)	-	6 (3.5)
Homemaker	1 (3)	-	2 (3.3)	3 (1.8)
Unemployed	5 (15.2)	4 (5.2)	1 (1.6)	10 (5.8)
Other	1 (3)	1 (1.3)	1 (1.6)	3 (1.8)
	^	^	^	^
Number of episodes				
1	11 (39.3)	13 (23.2)	-	24 (28.6)
2 - 4	10 (35.7)	19 (33.9)	-	29 (34.5)
5 - 19	6 (21.4)	12 (21.4)	-	18 (21.4)
20 +	1 (3.6)	12 (21.4)	-	13 (15.5)
n	28	56	-	84
Treatment for main MH problem				
Yes	32 (97)	75 (97.4)	-	107 (97.3)
No	1 (3)	2 (2.6)	-	3 (2.7)

Continuous Group Characteristics

Mean and standard deviations for continuous group characteristics were calculated per group (see Table 3.4). The three groups appeared comparable for age and MHAI-awfulness mean scores. There appeared to be a difference between the anxiety and control group for mean levels of anxiety (GAD-7). For all other variables, the control group appeared to differ from the two MH groups, however the psychosis and anxiety groups appeared comparable.

Table 3.4

Continuous characteristics of participants by group

	Recovery from psychosis	**Recovery from anxiety**	**Control**
	Mean (sd)	*Mean (sd)*	*Mean (sd)*
Age	35.44 (10.46)	32.34 (10.60)	35.49 (12.47)
Anxiety (GAD-7)	6.21 (5.78)	7.96 (5.06)	5.05 (4.44)
Low mood (PHQ-9)	9.06 (7.57)	9.04 (6.846)	5.18 (4.61)
Functioning (WSAS)	14.20 (10.36)	15.58 (7.89)	7.72 (7.62)
Functioning at worst (WSAS-worst)	33.36 (9.64)	30.14 (8.46)	12.33 (10.29)
Quality of life (ReQoL)	22.76 (9.78)	24.58 (8.26)	28.10 (6.93)
Mental Health Anxiety (MHAI)	20.24 (8.27)	19.44 (7.51)	9.15 (6.49)
Mental Health Anxiety-awfulness (MHAI-awful)	4.97 (3.20)	4.70 (2.56)	4.02 (2.36)
Fear of Relapse (FORSE)	51.21 (13.41)	47.59 (13.37)	-

Recovery Status of Mental Health Groups

The psychosis (M = 7.79, SD = 1.14) and anxiety (M = 7.92, SD = 1.10) groups appeared comparable for self-rated recovery, with a mean score of 7 indicating "moderately agree" and 8 "agree". The current self-rated severity of symptoms for the psychosis (M = 2.67, SD = 1.10) and anxiety groups (M = 3.10, SD = 1.12) also did not appear to notably differ. A mean score of 2 corresponded to 'very mild' and 3 to 'mild' current symptoms. For the MH groups, the mean PHQ-9 score was 9.05 (mild depression), the mean GAD-7 score was 7.44 (mild anxiety). The mean WSAS score was 15.17, falling within the 10-20 range associated with significant impairment in functioning but less severe

symptoms (Mundt, Marks, Shear & Greist, 2002). Furthermore, for the MH groups the mean ReQoL score was 24.04; on the borderline of the clinical range cut-off for (0-24) (Keetharuth et al., 2017). Considered together, the research team concluded the sample was sufficiently recovered to proceed to hypothesis testing.

Primary Hypothesis

The data were checked against the assumptions of parametric statistical tests before analysis (see Appendix T for details). A mixed-model ANOVA with group (psychosis, anxiety and control) as the between-subject and item type as the within-subject variable (psychosis-like, anxiety-like and external-control) (see Figure 3.1). Mauchly's test of sphericity indicated the assumption of sphericity was not met (Greenhouse-Geisser (2) =.94, p=.004), therefore Greenhouse-Geisser p's were reported. There were significant main effects of item type, $F(2, 330) = 5.65$, G.G p =.004 and group, $F(2, 168) = 16.31$, p <.001. These effects were modified by a significant group by item type interaction, $F(4, 336) = 7.13$, G.G p <.001.

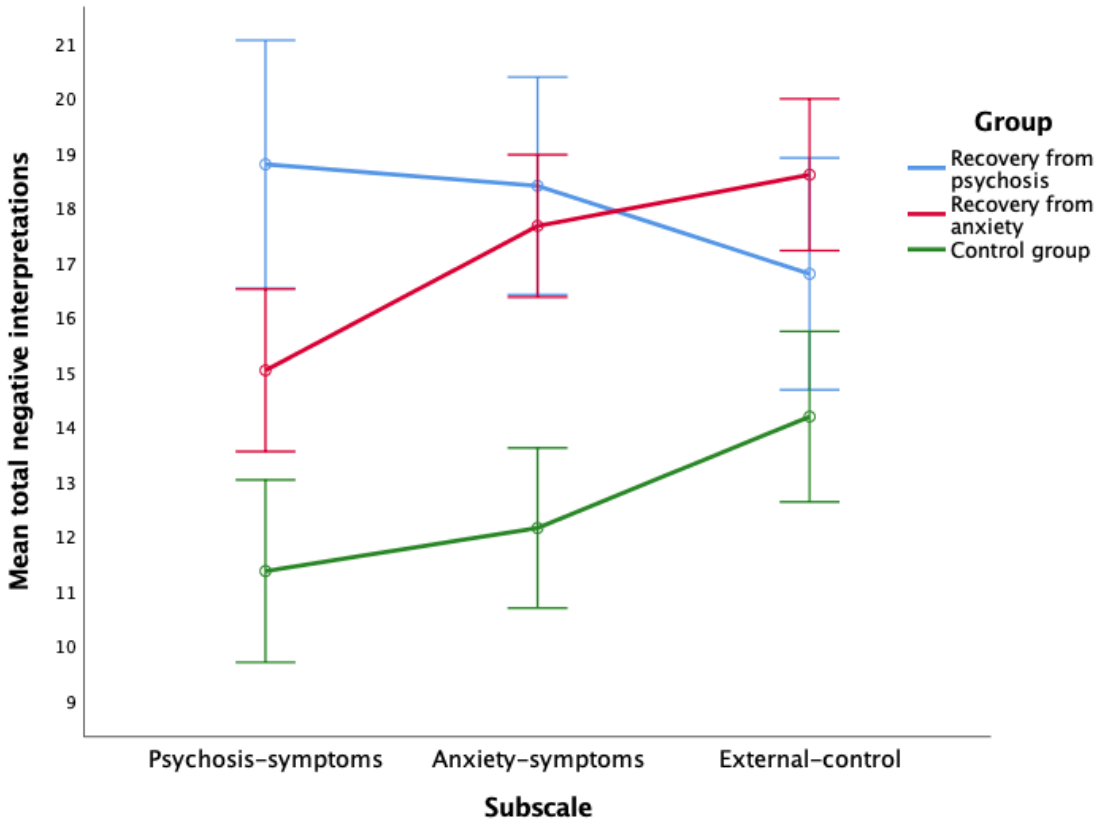

Figure 3.1: Interaction of group by EIQ item type for total negative interpretations, with CI (95%) error bars

As the interaction was significant, pre-planned one-way ANOVAs (simple main effects) were conducted by group for each of the three subscales (Table 3.5). Levene's test indicated a significant issue with homogeneity of variance for the psychosis-symptom subscale (p =.007) and control-item subscale (p =.017), therefore Dunnett's T3 reported for these subscales (Table 3.6).

There were significant differences in total negative interpretations of psychosis-symptoms between all groups, with the psychosis group significantly more likely to interpret psychosis items negatively than the anxiety (p =.036) and control groups (p <.001), and the anxiety group more likely to negatively interpret than the control group (p =.003) (Table 3.6).

For the anxiety subscale (LSD) there were significant differences between the psychosis and control groups (p <.001), and the anxiety and control groups (p <.001), on

total negative interpretations. No significant difference was found on negative interpretations of anxiety-symptoms between the psychosis and anxiety groups (p =.54), therefore both MH groups were significantly more likely to negatively interpret anxiety items than controls.

There were significant differences between the anxiety and control group in total negative interpretations of external-control items, however not between the psychosis and anxiety groups (p =.469) or psychosis and control groups (p =.148). The anxiety group were significantly more likely to negatively interpret external-control items than the control group (p <.001).

Table 3.5

Differences between groups by EIQ subscale

	Recovery from psychosis	**Recovery from anxiety**	**Control**	**ANOVA**			
EIQ Subscale	*Mean (sd)*	*Mean (sd)*	*Mean (sd)*	*F*	df	*p*	*r*
Psychosis-symptoms	18.79 (6.94)	15.03 (7.11)	11.36 (5.65)	14.14*	2, 168	<.001	.38
Anxiety-symptoms	18.39 (6.06)	17.66 (6.13)	12.15 (5.15)	19.36*	2, 168	<.001	.43
External-control	16.79 (6.55)	18.60 (6.71)	14.18 (5.14)	8.76*	2, 168	<.001	.31

*significant difference between groups at p<.05 level

Table 3.6

Mean differences, standard errors, significance and confidence internals between individual groups by EIQ subscale

EIQ Subscale	**Groups**	**Mean Diff**	**Std Error**	***p***	**95% CI**
Psychosis-symptoms	RP-RA*	3.76	1.45	.036	.20 - 7.32
	RP-C*	7.43	1.41	<.001	3.96 – 10.89
	RA-C*	3.67	1.09	.003	1.04 – 6.29
Anxiety-symptoms	RP-RA	0.73	1.20	.544	-1.64 – 3.11
	RP-C*	6.25	1.25	<.001	3.78 – 8.71
	RA-C*	5.51	.99	<.001	3.56 – 7.47
External-control	RP-RA	-1.81	1.37	.469	-5.17 - 1.55
	RP-C	2.61	1.32	.148	-.63 – 5.85
	RA-C*	4.42	1.01	<.001	1.98 – 6.85

Note: RP; Recovery from psychosis, RA; Recovery from anxiety, C; Control group. *significant difference between groups at p<.05 level

Secondary Hypotheses

An independent samples t-test indicated no significant difference in fear of relapse between the two MH groups, $t(107)= 1.30$, $p = .197$, $d= 0.27$, with a small effect size.

A hierarchical multiple linear regression was performed to consider whether MHA (independent variable) and FOR (covariate) predict negative interpretations of psychosis-symptoms (dependent variable) in the psychosis group. Tests indicated no concern regarding multi-collinearity (VIF = 1.85). MHA and FOR were not significant predictors, with the model accounting for 6.5% of variance in negative interpretations (Table 3.7).

A hierarchical multiple linear regression was used to test whether MHA (independent variable) and FOR (covariate) predict negative interpretations of anxiety-symptoms (dependent variable) in the anxiety group. Tests indicated multicollinearity was not an issue (VIF = 1.49). A significant model ($p < .001$) accounting for 41.7% of variance in negative interpretations of anxiety-symptoms was found (Table 3.7), with MHA being the only significant predictor.

Table 3.7

Model summary and beta values for multiple regression of mental health anxiety and fear of relapse as predictors of a) negative interpretations of psychosis-symptoms in psychosis group and b) negative interpretations of anxiety-symptoms in anxiety group

DV^	Model	R^2	Adjusted R^2	F change #	B	*β*	t	*p*
a) Psychosis-symptoms	MHA [a]	.123	.065	2.10	.14	.17	.71	.481
	FOR [b]				.11	.22	.93	.359
b) Anxiety-symptoms	MHA [a]	.432	.417	27.80*	.50	.60	5.61	<.001*
	FOR [b]				.04	.09	.82	.416

*significant at p<.001 level, [a]; Independent variable, [b]; Covariate; ^DV; Dependent variable, # F change refers to the change in F-statistic from fitting the model comparative to no predictors (Field, 2018).

Preliminary Psychometric Properties of EIQ

Pearson's correlation co-efficient indicated excellent test-retest reliability for the EIQ psychosis-symptoms ($r = .928$) and external-control ($r = .944$) subscales, and good test-retest reliability for the anxiety-symptoms subscale ($r = .889$).

Discussion

This study sought to investigate whether people in recovery from psychosis or anxiety negatively interpret symptom-like experiences related to their previous MH difficulties, as a first step towards exploring the possible role of negative appraisals within relapse.

Primary Hypotheses

People in recovery from psychosis interpreted psychosis-like experiences significantly more negatively than the other two groups. The anxiety and psychosis groups interpreted anxiety-related experiences significantly more negatively than the controls. The anxiety group significantly more negatively interpreted external-control items, potentially due to differences in anxiety between these groups. There appeared to be no differences between the MH groups in negative appraisals of external-control items, anxiety, depression, MHA, recovery or severity, suggesting the findings cannot be accounted for by generally interpreting situations more negatively or variations in these other factors.

The finding that people in recovery from psychosis were relatively more likely to interpret possible psychosis-symptoms negatively is consistent with the hypothesised role of appraisals in psychosis recurrence (Birchwood & Spencer, 2001; Gumley & Schwannauer, 2006). This also fits with research that fear of relapse predicts actual relapse (Gumley et al., 2015) and the proposed application of cognitive models (Rachman, 2012; Salkovskis, 1986) to relapse. These findings indicate that having prior experience of psychosis means people are more likely to interpret possible psychosis-symptoms as threatening. Considering arousal and affect-based models of relapse in psychosis (Gumley, 2006), this sense of threat is likely to increase negative emotions and physiological arousal, and potentially counterproductive safety behaviours such as avoidance, delayed help-seeking and hypervigilance. These cognitive, emotional and behavioural responses may in turn unintentionally increase unusual experiences, contributing to worsening relapse and potentially worse outcomes such as hospital admission, therefore fulfilling catastrophic interpretations. This study provides the first step towards testing this hypothesised cycle (Birchwood & Spencer, 2001; Gumley, 2006); that following prior experience of psychosis, appraising possible symptoms negatively (as indicative of relapse) may then increase anxiety, leading to further symptoms and thus

create a self-fulfilling prophecy. As negative interpretations of possible symptoms similarly occurred in recovery from anxiety a similar mechanism may also be present for this group.

People in recovery from psychosis were comparable to the anxiety recovery group for negative interpretations of anxiety-related symptoms. Whilst not specifically predicted, this is consistent with Morrison's (2002) cognitive model of psychosis proposing interpreting anomalous experiences as threatening causes people to feel anxious. Anxiety is a common experience during psychosis (Freeman & Freeman, 2008), thus people likely also negatively interpret other signs related to their previous MH difficulties, not just positive psychosis symptoms.

Secondary Hypotheses

Contrary to hypothesis two and previous research (Jamalamadaka, 2017), FOR was not significantly higher in recovery from psychosis comparative to anxiety. This conflicting finding may be due to differences in the clinical comparison group as Jamalamdaka (2017) included any MH difficulties without psychosis, thus FOR may also be of particular concern following anxiety. Alternatively, it could be explained by the previous study's findings being confounded by significant differences between the MH groups self-rated recovery. The FORSE was developed for psychosis and thus may lack specificity to relapse for the anxiety group as some items could relate to anxiety more generally.

When within-groups associations were considered, MHA nor FOR significantly predicted negative interpretations of psychosis-symptoms for the psychosis group. However, MHA did significantly predict negative interpretations of anxiety-symptoms for the anxiety group. This result is surprising given previous research (Jamalamadaka, 2017), and suggests variance in negative interpretations for the psychosis group are due to factors not measured within this study. Insight (into symptoms) and self-stigma may be potential candidates, as there is more research supporting their relevance to outcomes for psychosis than anxiety disorders (Ghaemi & Pope, 1994). For example, people who view anomalous experiences as relating to psychosis may be more likely to negatively interpret them, thus insight into symptoms may moderate the relationship with MHA or FOR. Increased insight within psychosis is associated with recovery but also negative outcomes such as depression (Lincoln, Lüllmann, & Rief, 2007) and lower psychological wellbeing;

relationships which are reportedly mediated by self-stigma (Cavelti, Kvrgic, Beck, Rüsch, & Vauth, 2012; Norman, Windell, Lynch & Manchanda, 2011).

Clinical Implications

Hewitt and Birchwood (2002) highlighted the importance of self-monitoring to reduce psychosis relapse. As suggested by a review of early signs monitoring (Eisner et al., 2013), this study's findings indicate encouraging self-monitoring may be unhelpful if this results in hypervigilance and catastrophising of low-level symptoms. Therefore, clinicians should consider attending to how people relate to their MH experience (both for psychosis and anxiety disorders) and to possible symptoms when in recovery, to ensure that self-monitoring leads to helpful responses rather than being potentially counterproductive.

The inclusion of interventions drawing on CBT principles to address catastrophic interpretations of possible symptoms may potentially be a useful addition to relapse prevention work. Consistent with panic and health anxiety treatment (Clark, 1986; Salkovskis & Warwick,1986), this could involve offering people alternative, less threatening explanations for their experiences (e.g. due to poor sleep/increased stressors) and testing these out using behavioural experiments.

The findings also tentatively support the idea of viewing recovery as relating to quality of life and functioning, rather than dependent on the absence of symptoms, as potentially helpful (Slade & Longden, 2015). If recovery is not dependent on experiencing symptoms, then people may be less likely to interpret the occurrence of anomalous experiences negatively.

Implications for Future Research

The findings suggest further research investigating how people in recovery interpret, and subsequently respond emotionally and behaviourally, to possible symptoms may be beneficial to better understand and prevent relapse. Tailoring this to people's idiosyncratic experience of MH difficulties may be useful to increase validity. Longitudinal research to explore whether negative interpretations play a causal role and are predictive of subsequent relapse may be particularly valuable.

Qualitative research to further elucidate how people may relate to possible symptoms of their previous MH difficulties may also be valuable. Robust research including assessment of mental health diagnoses and narrowly defined clinical comparison group inclusion criteria may be useful, as would further exploration of FOR across clinical groups to clarify the specificity of this concern to psychosis or/and anxiety.

Limitations

The main measure was developed for this study (EIQ) and therefore its psychometric properties are unknown, although test-retest reliability appears promising. As some of the data violate assumptions of parametric testing these results should be treated with caution. In relation to the non-significant findings, the psychosis group sample size was less than the *a priori* power calculation suggested.

Online data collection potentially restricted the sample's representativeness by excluding people without internet access. Postal completion was offered to address this but with limited uptake. The sample's homogenous nature may also limit generalisability of results; the majority of participants were Caucasian women with graduate education in paid employment.

Anonymous responses meant self-reported previous MH experience, recovery status and not meeting exclusion criteria was not verifiable. A validated measure of recovery such as the Recovery Assessment Scale (Law, Morrison, Byrne & Hodson, 2012) would have increased screening robustness comparative to the self-report Likert scale chosen for brevity and replication (Jamalamadaka, 2017).

Additionally, people had to self-identify as having experienced psychosis to participate, therefore those not viewing their difficulties in this way were likely excluded. Use of the Beck Cognitive Insight Scale (Beck, Baruch, Balter, Steer, & Warman, 2004) to define the sample may have been beneficial.

Conclusion

This study suggests people in recovery from psychosis or anxiety appraise possible symptoms of their previous difficulties negatively, comparative to those without prior MH experience. These findings indicate this may be a promising area warranting further research to explore the potential relationship between negative interpretations of

possible-symptoms and relapse. Furthermore, attending to how people appraise possible symptoms when encouraging early signs monitoring as part of relapse prevention planning may be beneficial.

References

Almond, S., Knapp, M., Francois, C., Toumi, M., & Brugha, T. (2004). Relapse in schizophrenia: costs, clinical outcomes and quality of life. *The British Journal of Psychiatry, 184*(4), 346-351.

Alvarez-Jimenez, M., Priede, A., Hetrick, S. E., Bendall, S., Killackey, E., Parker, A. G., . . . Gleeson, J. F. (2012). Risk factors for relapse following treatment for first episode psychosis: a systematic review and meta-analysis of longitudinal studies. *Schizophrenia research, 139*(1), 116-128.

Alvarez-Jiménez, M., Parker, A. G., Hetrick, S. E., McGorry, P. D., & Gleeson, J. F. (2009). Preventing the second episode: a systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis. *Schizophrenia Bulletin, 37*(3), 619-630.

Amador, X. F., & David, A. S. (2004). *Insight and psychosis: awareness of illness in schizophrenia and related disorders*: Oxford University Press.

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (Fifth ed.). Washington: American Psychiatric Association.

Bassett, M., Sperlinger, D., & Freeman, D. (2009). Fear of madness and persecutory delusions: Preliminary investigation of a new scale. *Psychosis, 1*(1), 39-50.

Beck, A. T., Baruch, E., Balter, J. M., Steer, R. A., & Warman, D. M. (2004). A new instrument for measuring insight: the Beck Cognitive Insight Scale. *Schizophrenia research, 68*(2-3), 319-329.

Birchwood, M. (2003). Pathways to emotional dysfunction in first-episode psychosis. *The British Journal of Psychiatry, 182*(5), 373-375.

Birchwood, M., Iqbal, Z., Chadwick, P., & Trower, P. (2000). Cognitive approach to depression and suicidal thinking in psychosis. *The British Journal of Psychiatry, 177*(6), 516-528.

Birchwood, M., & Spencer, E. (2001). Early intervention in psychotic relapse. *Clinical Psychology Review, 21*(8), 1211-1226.

Bowen, M., Kinderman, P., & Cooke, A. (2019). Stigma: a linguistic analysis of the UK red-top tabloids press's representation of 'schizophrenia'. *Perspectives in public health.*, 1757-9139.

Brett, C., Heriot-Maitland, C., McGuire, P., & Peters, E. (2014). Predictors of distress associated with psychotic-like anomalous experiences in clinical and non-clinical populations. *British Journal of Clinical Psychology, 53*(2), 213-227.

British Psychological Society, (2014). *Understanding Psychosis and Schizophrenia.* Division of Clinical Psychology, Canterbury Christ Church University.

Brown, S., Kim, M., Mitchell, C., & Inskip, H. (2010). Twenty-five year mortality of a community cohort with schizophrenia. *The British journal of psychiatry, 196*(2), 116-121.

Cavelti, M., Kvrgic, S., Beck, E.-M., Rüsch, N., & Vauth, R. (2012). Self-stigma and its relationship with insight, demoralization, and clinical outcome among people with schizophrenia spectrum disorders. *Comprehensive Psychiatry, 53*(5), 468-479.

Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy, 24*(4), 461-470. doi:http://dx.doi.org/10.1016/0005-7967(86)90011-2.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New York: Academic Press.

Commons, D., Greenwood, K. M., & Anderson, R. A. (2016). A preliminary investigation into worry about mental health: development of the Mental Health Anxiety Inventory. *Behavioural and cognitive psychotherapy, 44*(3), 347-360.

Eisner, E., Drake, R., & Barrowclough, C. (2013). Assessing early signs of relapse in psychosis: Review and future directions. *Clinical Psychology Review, 33*(5), 637-653. doi:http://dx.doi.org/10.1016/j.cpr.2013.04.001.

Field, A. (2018). *Discovering Statistics Using IBM SPSS Statistics.* (5th ed.). London: Sage Publications.

Freeman, D., Dunn, G., Startup, H., Pugh, K., Cordwell, J., Mander, H., . . . Kingdon, D. (2015). Effects of cognitive behaviour therapy for worry on persecutory delusions in patients with psychosis (WIT): a parallel, single-blind, randomised controlled trial with a mediation analysis. *The Lancet Psychiatry, 2*(4), 305-313.

Freeman, D., & Freeman, J. (2008). *Paranoia: The 21st century fear*: Oxford University Press.

Freeman, D., Garety, P. A., Fowler, D., Kuipers, E., Bebbington, P. E., & Dunn, G. (2004). Why do people with delusions fail to choose more realistic explanations for their experiences? An empirical investigation. *Journal of consulting and clinical psychology, 72*(4), 671.

Garner, E., Salkovskis, P. & Walker, J. (2015). *A test of a cognitive model of violence: a comparison of thinking in violent and non-violent men.* (Unpublished doctoral dissertation), Department of Psychology; University of Bath.

Garety, P. A., Fowler, D. G., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial. *The British Journal of Psychiatry, 192*(6), 412-423.

Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological medicine, 31*(2), 189-195.

Ghaemi, S. N., & Pope, H. G. (1994). Lack of insight in psychotic and affective disorders: a review of empirical studies. *Harvard Review of Psychiatry, 2*(1), 22-33.

Gumley, A., & Schwannauer, M. (2006). *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention*: John Wiley & Sons.

Gumley, A. I., MacBeth, A., Reilly, J. D., O'Grady, M., White, R. G., McLeod, H., . . . Power, K. G. (2015). Fear of recurrence: results of a randomized trial of relapse detection in schizophrenia. *British Journal of Clinical Psychology, 54*(1), 49-62.

Gumley, A. I., & Schwannauer, M. (2006). *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention*: John Wiley & Sons.

Hartley, S., Barrowclough, C., & Haddock, G. (2013). Anxiety and depression in psychosis: a systematic review of associations with positive psychotic symptoms. *Acta Psychiatrica Scandinavica, 128*(5), 327-346.

Hewitt, L., & Birchwood, M. (2002). Preventing relapse of psychotic illness. *Disease Management & Health Outcomes, 10*(7), 395-407.

Ialongo, C. (2016). Understanding the effect size and its measures. *Biochemia medica: Biochemia medica*, *26*(2), 150-163.

Jamalamadak, T. (2017). *How are fear of illness recurrence, health behaviours and psychological distress affected by mental defeat and mental health anxiety in people recovering from psychosis?* Manuscript in preparation, Department of Psychology; University of Bath.

Keetharuth, A., Brazier, J., Connell, J., Carlton, J., Buck, E. T., Ricketts, T., & Barkham, M. (2017). Development and Validation of the Recovering Quality of Life (ReQoL) Outcome Measures.

Kirkbride, J. B., Errazuriz, A., Croudace, T. J., Morgan, C., Jackson, D., Boydell, J., . . . Jones, P. B. (2012). Incidence of schizophrenia and other psychoses in England, 1950–2009: a systematic review and meta-analyses. *PloS one, 7*(3), e31660.

Koch, L., Bertram, H., Eberle, A., Holleczek, B., Schmid-Höpfner, S., Waldmann, A., . . . Arndt, V. (2014). Fear of recurrence in long-term breast cancer survivors—still an issue. Results on prevalence, determinants, and the association with quality of life and depression from the Cancer Survivorship—a multi-regional population-based study. *Psycho-Oncology, 23*(5), 547-554.

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G., & Bebbington, P. (2006). Cognitive, emotional, and social processes in psychosis: refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia bulletin, 32*(suppl_1), S24-S31.

Lally, J., Ajnakina, O., Stubbs, B., Cullinane, M., Murphy, K. C., Gaughran, F., & Murray, R. M. (2017). Remission and recovery from first-episode psychosis in adults: systematic review and meta-analysis of long-term outcome studies. *The British Journal of Psychiatry, 211*(6), 350-358.

Law, H., Morrison, A., Byrne, R., & Hodson, E. (2012). Recovery from psychosis: a user informed review of self-report instruments for measuring recovery. *Journal of Mental Health, 21*(2), 192-207.

Lee-Jones, C., Humphris, G., Dixon, R., & Bebbington Hatcher, M. (1997). Fear of cancer recurrence—a literature review and proposed cognitive formulation to explain exacerbation of recurrence fears. *Psycho-Oncology, 6*(2), 95-105.

Lincoln, T. M., Lüllmann, E., & Rief, W. (2007). Correlates and long-term consequences of poor insight in patients with schizophrenia. A systematic review. *Schizophrenia bulletin, 33*(6), 1324-1342.

Lloyd, C., Waghorn, G., & Williams, P. L. (2008). Conceptualising recovery in mental health rehabilitation. *British journal of occupational therapy, 71*(8), 321-328.

Morrison, A. P. (2002). THE INTERPRETATION OF INTRUSIONS IN PSYCHOSIS: AN INTEGRATIVE COGNITIVE APPROACH TO HALLUCINATIONS AND DELUSIONS. *Behavioural and Cognitive Psychotherapy, 29*(3), 257-276. doi:10.1017/S1352465801003010

Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *The British Journal of Psychiatry, 180*(5), 461.

National Institute of Clinical Excellence. (2014). *Psychosis and schizophrenia in adults: prevention and management.* NICE; London.

Norman, R. M. G., Windell, D., Lynch, J., & Manchanda, R. (2011). Parsing the relationship of stigma and insight to psychological well-being in psychotic disorders. *Schizophrenia Research, 133*(1-3), 3-7.

Ozga, M., Aghajanian, C., Myers-Virtue, S., McDonnell, G., Jhanwar, S., Hichenberg, S., & Sulimanoff, I. (2015). A systematic review of ovarian cancer and fear of recurrence. *Palliative & supportive care, 13*(6), 1771-1780.

Rachman, S. (2012). Health anxiety disorders: a cognitive construal. *Behaviour research and therapy, 50*(7-8), 502-512.

Reavley, N. J., Morgan, A. J., & Jorm, A. F. (2017). Predictors of experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Social psychiatry and psychiatric epidemiology, 52*(3), 269-277.

Robinson, D., Woerner, M. G., Alvir, J. M. J., Bilder, R., Goldman, R., Geisler, S., . . . Mayerhoff, D. (1999). Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of general psychiatry, 56*(3), 241-247.

Royal College of Psychiatrists. (2015). *Severe mental illness,* Retrieved from http://www.rcpsych.ac.uk/healthadvice/partnersincarecampaign/severementalillness.aspx

Salkovskis, P. M., Rimes, K. A., Warwick, H. M. C., & Clark, D. M. (2002). The Health Anxiety Inventory: development and validation of scales for the measurement of health anxiety and hypochondriasis. *Psychological medicine, 32*(5), 843-853.

Salkovskis, P. M., & Warwick, H. M. C. (1986). Morbid preoccupations, health anxiety and reassurance: a cognitive-behavioural approach to hypochondriasis. *Behaviour Research and Therapy, 24*(5), 597-602.

Simard, S., Savard, J., & Ivers, H. (2010). Fear of cancer recurrence: specific profiles and nature of intrusive thoughts. *Journal of Cancer Survivorship, 4*(4), 361-371.

Simonelli, L. E., Siegel, S. D., & Duffy, N. M. (2017). Fear of cancer recurrence: a theoretical review and its relevance for clinical presentation and management. *Psycho‐oncology, 26*(10), 1444-1454.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A., & Meltzer, H. (2003). Psychiatric morbidity among adults living in private households, 2000. *International Review of Psychiatry, 15*(1-2), 65-73.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*: Cambridge University Press.

Slade, M., & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC psychiatry, 15*(1), 285.

South London and Maudsley NHS Foundation Trust/South West London and St George's Mental Health NHS Trust. (2010). *Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists*. London: SLAM/SWLSTG.

Sparrowhawk, I. (2009). Recovering from psychosis: Personal learning, strategies and experiences. *Psychosis, 1*(1), 73-81.

Stainsby, M., Sapochnik, M., Bledin, K., & Mason, O. J. (2010). Are attitudes and beliefs about symptoms more important than symptom severity in recovery from psychosis? *Psychosis, 2*(1), 41-49.

Tarrier, N., & Wykes, T. (2004). Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? A cautious or cautionary tale? *Behaviour Research and Therapy, 42*(12), 1377-1401.

Taylor, H. E., Parker, S., Mansell, W., & Morrison, A. P. (2013). Effects of appraisals of anomalous experience on distress in people at risk of psychosis. *Behavioural and cognitive psychotherapy, 41*(1), 24-33.

Vancleef, L. M. G., & Peters, M. L. (2008). Examining content specificity of negative interpretation biases with the Body Sensations Interpretation Questionnaire (BSIQ). *Journal of anxiety disorders, 22*(3), 401-415.

Warwick, H. M. C. (1989). A cognitive-behavioural approach to hypochondriasis and health anxiety. *Journal of Psychosomatic Research, 33*(6), 705-711.

White, R. G., & Gumley, A. I. (2009). Postpsychotic posttraumatic stress disorder: Associations with fear of recurrence and intolerance of uncertainty. *The Journal of nervous and mental disease, 197*(11), 841-849.

Wood, L., Birtel, M., Alsawy, S., Pyle, M., & Morrison, A. (2014). Public perceptions of stigma towards people with schizophrenia, depression, and anxiety. *Psychiatry research, 220*(1), 604-608.

Executive Summary

Background

Experiencing mental health problems can be very distressing. People who have previously experienced psychosis are understandably often afraid of experiencing it again (referred to as a relapse). Research has found that when people in recovery from psychosis are more afraid of relapsing, they can be more likely to actually have a relapse. However, we do not currently know why this is. Some psychological theories suggest that it is the meaning people make of their experiences which leads to distress, rather than the experience itself. Therefore, we wondered if people in recovery who have an experience similar to their previous mental health symptoms might negatively interpret this to mean they are going to have a relapse, which might then make them feel anxious and worsen the symptoms and so lead to actual relapse.

Aims

This study aimed to take the first step in investigating this idea. This study explored whether people in recovery from psychosis would think the worst (catastrophise) when asked to imagine having experiences which could be symptoms of psychosis, interpreting them to mean they are going to have a relapse. We also investigated if people in recovery from anxiety disorders had a similar tendency to think the worst about possible anxiety symptoms. A previous study found people who have experienced psychosis were more afraid of relapse than other groups, so we wanted to replicate this. We also wanted to find out if there are any links between being anxious about your mental health, being afraid of having a relapse and catastrophising about possible symptoms.

Method

Thirty-three people in recovery from psychosis, 77 people in recovery from anxiety disorders and 61 people with no previous mental health experience were recruited online or via local NHS services. People were included in the anxiety disorders group if they had experienced obsessive-compulsive disorder, generalised anxiety disorder, social anxiety disorder or panic disorder. They completed a questionnaire pack online which took about 45 minutes. This included the 24-item Experiences Interpretation Questionnaire (EIQ) which was developed for this study based on an existing questionnaire with input from

people with personal experience. The EIQ had three types of items: psychosis-like experiences, anxiety-like experiences and external-control items. Psychosis-like items and anxiety-like items were based on the diagnostic criteria for these mental health problems. The external-control items were day-to-day situations where there could be multiple explanations for what was happening and were included to check if people were answering questions more negatively in general. Thirty-two of the people who took part completed the EIQ again approximately two weeks later so we could check if this new measure was reliable.

Results

As expected, we found that people in recovery from psychosis interpreted psychosis-like experiences significantly more negatively than the other two groups. We also found that people who had experienced psychosis or anxiety negatively interpreted anxiety-like experiences similarly, and both significantly more negatively than people without previous menta health problems. This could be because anxiety is often a common experience during psychosis. The anxiety group more negatively interpreted the external situations than the group with no previous mental health problems, which could be because they were also significantly more anxious. There were no differences in how the psychosis and anxiety groups interpreted the external situations, so generally interpreting things more negatively is unlikely to explain the difference in how they responded to the psychosis-like items.

Contrary to previous research, people who had experienced psychosis did not have significantly highly fear of relapse than people who had experienced anxiety. This might be due to the different comparison group used, or because in the previous study one group was more recovered than the other (which was not the case in the current study). Mental health anxiety and fear of relapse did not significantly predict negative interpretations of psychosis-like items in the psychosis group. Mental health anxiety did predict negative interpretations of anxiety-like items in the anxiety group. Comparing people's first answers on the EIQ with their second ones two weeks later showed that the EIQ subscales had good test-retest reliability.

Implications

These findings suggest that people in recovery from psychosis or anxiety may negatively interpret possible symptoms relating to their previous mental health difficulties. When people who have had psychosis are recovering, mental health clinicians often encourage them to look out for signs of things getting worse again so they know when to seek help. This study's findings suggest that it might be important for clinicians to check how people would interpret these possible symptoms if they happened. This could be important to make sure that this self-monitoring leads to helpful responses rather than causing people to catastrophise about them, which could end up making them feel worse and so be counterproductive.

These findings are interesting and suggest more research is needed. Studies with people from a wider range of backgrounds (e.g. ethnicity, education) and with verifiable mental health history would make the results more convincing. Using longer-term research to investigate whether negatively interpreting possible symptoms increases the chances of someone relapsing would be particularly valuable.

Connecting Narrative

This narrative describes and reflects on the process of designing and conducting research during training, and my learning from this experience. This includes the literature review, service improvement project, main research project and case studies.

It feels important to say that over the last two years of training I have experienced personal health difficulties and both mental and physical health emergencies within my family. At times these have impacted my progress with the research component of the course, however I have pushed through and am pleased to now be on track to viva with the rest of my cohort.

Literature Review (LR)

When the topic of the difficult dynamics between services and people with a diagnosis of borderline personality disorder came up in discussions with a course staff member, this immediately caught my attention. This issue was close to my heart as I had witnessed these difficult relationships play out during my pre-training experience as a healthcare assistant in acute and prison settings, often to the detriment of everyone involved. My desire to make sense of this was bolstered during teaching with people with personal experience who shared that they had experienced the most stigma from services. I was surprised this hadn't been attempted before and felt excited at the prospect of trying to understand this and thus potentially inform improvements.

Considering the wide range of possible factors involved, a conceptual approach was proposed, however as I started reading, I became concerned about the feasibility of finding and digesting the literature on so many topics. I spent a long time trying to narrow down the question to allow for a systematic search, but every alternative seemed to miss important elements and thus provide an incomplete explanation.

At this point my supervisor left the course. This felt like a huge set-back since she was the only course member with an interest in personality disorders and she shared my passion for the topic. I was grateful when she offered some input when possible around NHS commitments as an external supervisor alongside an additional internal supervisor.

After further discussion and exploration of various options, we agreed that a conceptual review was the most appropriate way to address this question. I read various examples of conceptual reviews and spoke to other trainees who had previously used this approach, finding other people had not used a particular step-by-step method. As someone who finds structure and clear steps helpful to manage uncertainty, this approach was anxiety-provoking at times. However, the enthusiasm of clinicians and PPEs about the clinical relevance and utility of this review whenever I discussed it helped me to tolerate this and persevere.

I began reading endless papers and often found hours passed by without realising due to my appetite for the topic. I was surprised that many issues which seemed evident from conversations in clinical teams, twitter debates and online SU blogs were not apparent in the published literature. It felt important the ideas came from the literature but holding all of this in my head or making comprehensive notes on everything wasn't feasible. My understanding of the topic grew, however drawing such a wide range of literature into a cohesive document of a set length was challenging and sometimes stalled my writing. The challenge of committing words to paper was enhanced by difficulties around structuring this without the usual pro-forma to follow, and concerns about getting it 'right' on what I viewed as an important issue. Offering a CPD session on the topic within placement helped me clarify the overarching themes within the literature. I felt apprehensive about phrasing things around people's responses to each other as I did not want this to be perceived as blaming, but I was also aware of SU discourses around not excusing unacceptable staff behaviour due to service pressures. In retrospect, beginning writing earlier rather than reading and thinking for so long may have been helpful to afford more time to face and work through difficulties head on, and I think this has taught me to try and give things a go earlier rather than over-planning for potential problems.

Despite the challenges of taking an approach which has often felt time-intensive and unclear, I have gained an appreciation of the work that goes into theoretical papers. I have wondered whether this may have been easier if I was more established in my career, as I have noticed these reviews are often authored by experts in the field. I have gained skills in consuming research and developed my ability to formulate complex problems using the evidence base. I believe this review will have clinical utility in offering a useful way to understand this issue.

Service Improvement Project (SIP)

Being new to Somerset and envisaging myself working in secondary care upon qualifying, I was keen to use the SIP to build connections with a local adult MH service. Initially I considered a project with an eating disorders service, however when I heard a new Mentalisation-Based Therapy service was seeking assistance around evaluation and improvement I was keen to pursue this opportunity to learn more about this approach. I initially hoped this project would be a contained and manageable choice, and therefore on balance enable me to embrace more resource intensive methods and populations for my other projects. However various difficulties meant this project took much more of my time than anticipated.

Originally my external supervisor was keen for the project to identify and test a method of measuring outcomes and gaining feedback for the MBT programme, and then using this to evaluate effectiveness to demonstrate to commissioners and suggest improvements based on SU feedback. My internal supervisor suggested also investigating when change occurs, in light of limited evidence about required intervention length. As the group was due to start in September, I worked hard to get the materials together quickly in the month between PAS approval and the last ethics committee meeting before summer recess. This involved identifying measures, designing the qualitative measures and interview schedule with input from PPE's, and consultation with the team. After lots of arduous back and forth clarifying various issues with Bath Uni ethics and AWP R&D, approval was gained, and I attended the service to introduce the project to SUs and begin baseline data collection.

I was disappointed to see there were substantially less people in the group than expected, and measure completion was lower than predicted despite attending the service regularly to input data and encourage the group facilitators to prompt this. One person dropped out, but my back-up plan didn't work as they did not attend the interview we arranged.

After six months, we reviewed the data and decided to extend the project for a further six months to allow additional data collection including another cohort, and ethical approval was sought. However, the second cohort was also much smaller than expected and poor measure completion rates continued despite regular calls and visits. During this time my internal supervisor left the course, and supervision passed first to one internal

supervisor and then to a third, due to further changes in course staffing. These multiple supervisor changes unfortunately occurred at difficult stages in the project, as recruitment was challenging, and each supervisor had different perspectives on how to progress. They also left me feeling alone with the project as no-one else had an overview of the whole journey. Through further consultation with the MBT team and discussions with the course director and my third supervisor, it was concluded that the existing data was unable to answer the original aims of the project. We agreed that it would be more useful to focus upon engagement, acceptability and feasibility of offering this service and evaluation of the assessment methods. Although logical, this was frustrating considering the effort that had gone into this. Analysing qualitative data was new to me and I enjoyed this process. This project highlighted to me that identifying when things are not working is just as important as evidencing when they are, as is seeking SU feedback on experience of completing measures.

On reflection, the resources I put into this project early on potentially meant I felt invested in continuing despite signs of problems. This sunk cost bias led me to focus on the next immediate step rather than seeing the big picture. This has been a big learning point for me. This project introduced me to the real-life challenges of conducting research within busy NHS services, particularly when having little control over data collection, and I think this experience has helped me become more aware of potential pitfalls when designing improvement projects in future services I work in.

Main Research Project (MRP)

I came to the course with lots of different areas I was interested in exploring for my main research project and spent a long time reading around and discussing these with various supervisors, researchers and PhD students across the country and on Twitter. These included compassion-focused therapy for psychosis, shame and self-criticism in oncology patients, compassion in older adults, emotional versus declarative memory in Alzheimer's and stigma when difficulties are presented as trauma versus psychosis. Sadly one-by-one they were deemed too ambitious, not suitable for the course requirements or already being investigated. As my final idea fell through, I deferred PAS until September and approached my now supervisor for direction as I was particularly keen to conduct research related to psychosis due to my previous inpatient work and as this group is often less likely to be offered psychological interventions. She was co-supervising a 3rd year

trainee project with interesting findings around fear of relapse and suggested building on this.

I did some reading around the area and was interested in why fear of relapse may lead to actual relapse. We discussed the idea of investigating how people respond to possible symptoms when in recovery, although I initially had reservations about doing this using the quantitative methodology required by the course. Whilst trying to develop the question and methodology I became focused on possible flaws which was paralysing at times, and my supervisors repeated to me like a mantra ‘all research has limitations’.

Developing the primary outcome measure questionnaire was both time intensive and surprisingly difficult. Thinking of situations with multiple possible explanations which were not interpersonal for external-control items was particularly challenging. I felt very uncomfortable with the use of colloquial language suggested by my supervisors as alternative catastrophising responses as I perceived this as potentially offensive or stigmatising. However, PPEs disagreed with me and spoke about preferring this to ‘fluffy’ psychology language. They suggested phrasing the responses as ‘I’ not ‘You’ so they read how you might speak to yourself rather than as the researcher saying it to you. I found their input incredibly helpful and a useful reminder not to make assumptions, although I recognise that the views of the three people I consulted cannot represent the views of everyone.

My supervisors were keen for me to experience the NHS ethics process, and I was surprised by how laborious and bureaucratic it was. Once I finally completed the online forms, I attended my NHS ethics panel of over 15 people in Southampton. This was an intimidating but interesting experience; I was surprised by the questions which were not at all the concerns I had myself and grateful for phone support from my second supervisor. I anxiously awaited the outcome, followed by a long back-and-forth of email requests for small wording tweaks from both my panel and HRA, which I later learnt is not usual practice. Approval was finally agreed, followed by application for University Ethics and overcoming various hurdles to gain permission from local trusts Research and Development departments.

With concerted effort liaising with relevant charities online, shipping posters to Gloucester for services to distribution with discharge letters and messaging and emailing everyone I could think of, recruitment for the anxiety and control group went relatively

smoothly and I was humbled by people's kindness in sharing the study or offering encouragement. However, recruiting people with experience of psychosis was much more challenging, potentially impacted by the lack of face-to-face contact and long questionnaire (which I noticed many people started but didn't finish). I discovered there are multiple barriers to NHS recruitment, particularly when relying on busy clinicians sharing the study information with people. Despite attending various team meetings, putting up and handing out posters in waiting rooms and numerous phone calls and emails I was disappointed that I recruited a very small number from services. However, I hope this experience of the NHS ethics process will prove useful in the future, with familiarity of the steps and requirements bringing more efficiency and confidence in navigating this and a more realistic understanding of timescales around this. I persevered with recruitment past my planned timeframe, contacting various groups and paying for advertisements, and although I did not get the sample required by my power calculation I was relatively pleased with my final number. I was contacted by some participants to further discuss the study and found these conversations stimulating. People who had experienced psychosis repeatedly shared that they panicked when noticing their early warning signs in part due to previous experience of a lack of support from services until things had significantly deteriorated into full relapse.

Having completed quantitative research during my MSc I was expecting the statistical analysis to go smoothly. I was surprised how little I initially remembered; however, once I got stuck in this started coming back to me. My second supervisor kindly offered me support with this process which I was grateful for. I was also keen to understand the analysis myself, feeling surprised that the best course of action was not always clear-cut even in statistics, which led me to spend days poring over Andy Field's SPSS book and watching YouTube videos to increase my learning.

This project has taught me a lot about the research process, and I think the findings are a useful addition to the field.

Case Studies

The logistics surrounding case studies initially seemed daunting. However, as the placements progressed, I became more familiar with planning and structuring case studies and valued and enjoyed these pieces of work.

I found completing case studies varied in difficulty across placements. Although not my original plan, on my working age adult placement ended up writing up my first

experience of using Compassion-Focused Therapy (closely supervised) and found this process useful to consolidate my learning about the approach. I think the opportunity to think in detail about the rationale for using a particular intervention has enhanced my ability to apply the evidence-base to practice.

I sought an additional BABCP supervisor on my CAMHS placement to supervise some CBT casework as I had not yet had this experience and was keen to further develop these skills. Accordingly, I found this case study the most straight-forward to write up whilst also having heuristic value in considering the overlaps between health anxiety and obsessive-compulsive disorder, and it is work I am particularly proud of.

On my learning disability placement, I had more cases where people's attendance was sporadic, and I found myself spending more time working with the network around people than hours in sessions. Consequently, my case study was on only five sessions of therapy and I found this the most difficult to write up, not least due to the limited scope and idiosyncratic nature of the intervention. However, once I began I found it reassuring to outline the theoretical underpinnings of my approach, and it highlighted to me the importance of considering potential barriers to engagement. Balancing interventions being led by individual formulation whilst also grounded in the evidence base has felt challenging at times, particularly with more complex difficulties or groups where the literature around interventions is limited. Writing case-studies has taught me that 'good-enough' therapy does not always go exactly as in textbooks or training videos by experts

I have noticed my reflections on case studies have often focused on the role of the therapeutic relationship on progress and outcomes of the work. I have really appreciated this opportunity to reflect on and evaluate my practice, particularly when time-pressures have afforded less space for this in supervision. I have found the process of physically writing about clinical work useful to clarify my thinking and learning and is something I intend to continue once qualified.

Summary and Future Aspirations

I have personally found the research component of the course the most challenging. I have particularly struggled with tolerating uncertainty when ideas or next steps are unclear and being flexible and adaptive in the face of challenges. This experience has helped me develop in these areas and despite the anxiety this has brought I think these improvements will be valuable for many aspects of my career.

Throughout this course I've been reminded that the research projects are as much about learning as they are about the final pieces of work. I think in this respect I have gained valuable skills and understanding about all stages of research and I hope to pursue opportunities to continue to develop and use these in my future career. Dissemination is a key part of the research process and I intend to attempt to publish as much of my work as possible after the course.

Acknowledgements

Thank you to my placement supervisors for the time and opportunities you all afforded me to develop. I have come away from each placement with new skills and insights and I truly appreciate the investment you made in my learning.

To each of my research supervisors, thank you for your help, support and encouragement with the research process: Paul Salkovskis, Emma Griffith, Taruna Jamalamadaka, Megan Wilkinson-Tough, Catherine Butler, Jennie Boland and Maria Loades (as commissioner of my consultancy project). A special thanks goes to my clinical tutor (and final SIP supervisor) Liz Marks for the understanding and containment you have offered me throughout this course. To my personal support tutor Jennifer Collins, I've really appreciated the space you've offered me to reflect (and regular hot chocolates).

Thank you to all the people who generously gave up their time to take part in my research and made these projects possible, and everyone who helped spread the word.

To my family and friends, thank you for all the patience, kindness and reminders that I am more than the course. It's been a tough few years for lots of you in different ways. I am incredibly grateful to you all for the heaps of understanding when I've not been able to be around as much. Mum, you've always told me I could do anything I put my mind to. Thank you for all the fish fingers, words of encouragement and tirelessly spreading the word about my study to everyone you met.

Andy, you mean the world to me. You have fed and watered, comforted and cheer-leaded me, been my secure base, lifted me up and made me laugh. I'm so grateful for your support and consistent belief in me even when I have struggled to believe in myself, for all the little things you do every day and the big things like moving across the country with me to go on this journey. We make the best team and I can't wait to have more time to enjoy being with you.

I have felt so incredibly lucky and privileged to have spent three years with such a kind-hearted, thoughtful, inspiring bunch of women. They weren't exaggerating when they said your cohort will be your best support system during the course. I can't think of a better group of people to have been on this journey with and I am so proud of us. A special mention to my pizza-loving, tea-guzzling, 'mood-boosting' study buddy Anna. Thank you for all the times you helped me laugh instead of cry, I couldn't have done this without you.

Appendices

Appendix A: Personality Disorder: Theory, Research and Treatment Author Guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

Personality Disorders: Theory, Research, and Treatment® (*PD:TRT*) is now using a software system to screen submitted content for similarity with other published content. The system compares each submitted manuscript against a database of 25+ million scholarly publications, as well as content appearing on the open web.

This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material). A similarity report will be generated by the system and provided to the *PD:TRT* Editorial office for review immediately upon submission.

To submit to the Editorial Office of Thomas A. Widiger, please submit manuscripts electronically through the Manuscript Submission Portal (.rtf, .doc, or .pdf files).

In addition to addresses and phone numbers, please supply email addresses and fax numbers for use by the editorial office and later by the production office. Most correspondence between the editorial office and authors is handled by email, so a valid email address is important for the timely flow of communication during the editorial process.

Keep a copy of the manuscript to guard against loss.

Masked Review Policy

PD:TRT uses a masked reviewing system for all submissions. Omit the authors' names and affiliations on the first page of the manuscript, but include the title of the manuscript and the submission date.

Please ensure that the final version for production includes a byline and full author note for typesetting.

List five keywords on the title page to facilitate the selection of peer reviewers. Additionally, provide a cover letter indicating the proposed category under which the manuscript was submitted (e.g., Brief Report) and up to four suggestions for potential reviewers.

Types of Manuscripts

Four types of manuscripts will be accepted:

full-length articles

brief reports

target conceptual articles

practice reviews (jointly written by a researcher and primary clinician)

Additionally, Invited peer commentaries in response to the target conceptual articles will be published online at the *PD:TRT* homepage. Further, the journal will operate an open-access message board to foster continuing dialogue on the target conceptual article.

Full-Length Articles

Manuscripts presenting empirical findings may be submitted as full-length articles. Full-length articles should not exceed 36 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double-spaced.

Brief Reports

In addition to full-length manuscripts, *PD:TRT* will consider brief reports of empirical findings. Brief reports are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 18 pages.

Target Conceptual Articles

Manuscripts that evaluate and synthesize the research literature and/or make important theoretical contributions are sought for target conceptual articles. Four commentaries invited by the journal will be published on the *PD:TRT* homepage, along with the author's response to the commentaries.

Target conceptual articles are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 40 pages.

Practice Reviews

In line with the journal's commitment to bridging science and practice, practice reviews will present an issue from clinical practice, review relevant research, and provide a practical recommendation informed by the reviewed research.

Practice reviews MUST be coauthored by at least one individual with a primary focus in clinical practice and at least one individual with a primary focus in research. This partnering of individuals with a different professional emphasis is crucial for practice reviews to provide a credible bridge between research and practice.

When submitting a practice review, provide a description of each individual's primary professional focus in the cover letter. Manuscripts not meeting this partnering requirement will be returned without review. New collaborations are especially encouraged.

Practice reviews are to be prepared in line with the guidelines for full-length articles, yet they may not exceed 30 pages.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES®database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article:
Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566

Authored Book:
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.

Chapter in an Edited Book:
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

$900 for one figure

An additional $600 for the second figure

An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

In light of changing patterns of scientific knowledge dissemination, APA requires authors to provide information on prior dissemination of the data and narrative interpretations of the data/research appearing in the manuscript (e.g., if some or all were presented at a conference or meeting, posted on a listserv, shared on a website, including academic social networks like ResearchGate, etc.). This information (2–4 sentences) must be provided as part of the Author Note.

Authors of accepted manuscripts are required to transfer the copyright to APA.

For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK
Publication Rights (Copyright Transfer) Form (PDF, 83KB)

For manuscripts funded by the Wellcome Trust or the Research Councils UK
Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conductelectronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix B: Rationale for Conceptual Approach

A systematic review was initially considered, however papers returned by pilot searches predominantly pertained to evidence of the problem rather than being explanatory. Existing reviews have established the presence of problematic staff attitudes towards this group (Dickens et al., 2016; Sansone & Sansone, 2013) and few additional papers published since, thus a further review on this topic would have had limited value. Taking a narrower focus (e.g. only using psychological models of BPD) was explored, however this approach risked missing key contributory factors within services and thus providing an incomplete explanation. Consequently, a conceptual approach was taken to allow a wide range of relevant literature to be considered whilst remaining feasible.

Appendix C: Service Improvement Project University of Bath Ethical Approval and Amendment Approvals

psychology-ethics
Wed 26/07/2017 10:13
Rebecca Sired; psychology-ethics; Megan Wilkinson-Tough

Dear Rebecca,

Thank you for taking the time to make these amendments and clarifications. I am happy to confirm that you have full ethical approval for this amended application. Please use the code 17-194 as proof of ethical approval on all internal documentation.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

From: psychology-ethics
Sent: 14 November 2017 09:18
To: Rebecca Sired
Subject: RE: Ethics 17-194

Dear Rebecca,

Thank you for letting us know about this amendment. I am happy to confirm that you have received full ethical approval, via Chair's Action. Your file will be updated to include these changes.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

Ethics 17-194 Amendment approved

psychology-ethics

Tue 20/02/2018 10:48

To:Rebecca Sired <R.Sired@bath.ac.uk>;

Dear Rebecca,

Thank you for letting us know about these amendments. I am happy to confirm that you have received full ethical approval, via Chair's Action. Your file will be updated to include these changes.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

Appendix D: AWP Research and Development Approval and Amendment Approvals

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Avon and Wiltshire Mental Health Partnership AWP Trust
AWP Quality Academy
Fromeside- East Wing
Manor Road
Fishponds
BS16 2EW

0117 378 4217

Date: 1st August 2017

Dear Rebecca,

Evaluation of Mentalisation-Based Therapy (MBT) for Borderline Personality Disorder in a secondary care service

AWP Reference: E2017.014

This letter is to confirm that your evaluation is now approved and also provides you with our reference number.

If you do need any further support or information, please contact us using the contact details above, quoting our reference number for your study.

The importance of disseminating all evaluation work cannot be over emphasised. It is only by sharing our learning that we can improve services across AWP. For this reason, the findings of all evaluation work should be reported to the Evaluation team via email. The team will champion the results of service evaluations, and work with evaluators to ensure those results are disseminated and acted upon, and that the results of evaluations are reflected in future service delivery. The team will also work with evaluators to produce publications for the public domain. I very much look forward to receiving the results of your evaluation in due course.

Please also remember that all service evaluation work must be represented as such in future publications or presentations.

Yours sincerely,

Bryony McCann

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Avon and Wiltshire Mental Health Partnership AWP Trust
AWP Quality Academy
Fromeside- East Wing
Manor Road
Fishponds
BS16 2EW

0117 378 4217

Date: 15th November 2017

Dear Rebecca,

Evaluation of Mentalisation-Based Therapy (MBT) for Borderline Personality Disorder in a secondary care service

AWP Reference: E2017.014

This letter is to confirm that the amendment of your evaluation is now approved and also provides you with our reference number.

If you do need any further support or information, please contact us using the contact details above, quoting our reference number for your study.

The importance of disseminating all evaluation work cannot be over emphasised. It is only by sharing our learning that we can improve services across AWP. For this reason, the findings of all evaluation work should be reported to the Evaluation team via email. The team will champion the results of service evaluations, and work with evaluators to ensure those results are disseminated and acted upon, and that the results of evaluations are reflected in future service delivery. The team will also work with evaluators to produce publications for the public domain. I very much look forward to receiving the results of your evaluation in due course.

Please also remember that all service evaluation work must be represented as such in future publications or presentations.

Yours sincerely,

Bryony McCann

Research & Development

NHS
Avon and Wiltshire Mental Health Partnership
NHS Trust

Rebecca Sired
Clinical Psychologist in Training
University of Bath
r.sired@bath.ac.uk

(by email)

28th February 2018

Avon and Wiltshire Mental Health Partnership AWP Trust
AWP Quality Academy
R&D Department
Fromeside- East Wing
Manor Road
Fishponds
BS16 2EW

0117 378 4217

Dear Rebecca,

Re: Evaluation of Mentalisation-Based Therapy (MBT) for Borderline Personality Disorder in a secondary care service

AWP Reference: E2017.014

Thank you for your email of 18.2.18 to request 3 amendments to your service evaluation project. I am sorry for the delay, but Bryony McCann who dealt with Service Evaluation for the trust left in January 2018.

You requested the following amendments:

"-The additional participant/s for whom the below amendment to include was approved have been delayed in starting the group. They are now joining the group on 28th February, and therefore data collection will continue (if approval is given) for 6 months until September 2018.

-Data collection for the current 4 participants will also continue until September 2018 if they consent to this (currently due to finish end of March). I have amended the end date on the consent form (Appendix C) and am meeting with the participants to discuss this and for them to complete the additional consent form if they agree on 28th Feb.

-Finally, I have added 2 questions to the 6 month feedback questionnaire as these have been requested by the service (Appendix K; Q5 and Q6). Please find this and the amended consent form attached. All other materials, procedures and ethical considerations remain the same. "

This letter is to confirm that the amendments of your evaluation are now approved and we are grateful that you have been responsive to the service needs. I hope this letter allows you to successfully complete the project in time for the course and the service.

Appendix E: SIP Information Sheet

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
banestherapiesadmin@nhs.net

UNIVERSITY OF BATH

Ethical approval code 17-194

Evaluation of Mentalisation-Based Therapy (MBT) in a secondary care service

We would like to invite you to take part in a study. Before you decide to take part, it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. The researcher running this project is a Clinical Psychologist in Training at the University of Bath and not a member of staff with the BANES therapies team.

Background
This is a study to measure the effectiveness of the first 6 months of the MBT programme at Bath NHS House. The aim of this is to help improve the service in the future. There is evidence that MBT is an effective treatment for people who experience difficulties associated with the diagnosis 'borderline personality disorder'. However we do not know when these benefits occur during the 18 month programme. We would also like to find out more about people's experience of the MBT programme to make suggestions of ways to improve it. Our results will be shared with the MBT team at Bath NHS House. Our results may eventually be published in a scientific journal, and may also be reported at scientific meetings.

What will I be asked to do?
You have been asked if you want to participate as you are enrolled in the MBT programme at Bath NHS House starting in September 2017. However, participation in the study is entirely voluntary. It is up to you to decide whether or not to do this.

Questionnaire part of the study
If you took part, we would ask you to complete a short questionnaire which asks about difficulties associated with 'borderline personality disorder' once a week for the next 4 weeks before the MBT programme starts in September. This is so we have an idea of how things were for you before you started the programme. We ask you to complete this for 4 weeks in a row as we know that everyone has some weeks which are better or worse than others. We will send you an email reminder to complete this questionnaire each week. You would then be asked to complete the same questionnaire and a feedback form at the end of the MBT group each week. You would also be asked to complete 3 more questionnaires at the beginning of the programme, 3 months later and 6 months later. Finally, we would ask you to complete a feedback form at the end of the 6 months about your experience of the MBT programme overall so far. Each questionnaire will take 5 minutes or less to complete.

You would be asked to complete these questionnaires as part of the MBT programme whether you take part in the project or not. However, if you decide not to take part then your data will not be included in the evaluation of the MBT programme and would only be used for clinical purposes.

Interview part of the study
We hope that you get the most of the group and continue as long as you and the therapists think it is helpful to do so. Should you decide to leave the MBT programme early then we would like to contact you to find out about your experience of the programme and what led to your decision to leave. We would only do this if you were happy for us to do so and if you were still under the services of AWP. This would be separate from any contact or meetings you might have with MBT staff about leaving the programme. We will give you more information about this study if it becomes relevant to you at a later stage.

At the end of the project (end of February 2018) you will be provided with another information sheet about the study and the opportunity to ask any other questions.

If you have any concerns related to your participation in this study, please direct them to the Psychology Research Ethics Committee, via Nathalia Gjersoe (n.gjersoe@bath.ac.uk)
0117 9287841

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
banestherapiesadmin@nhs.net

Do I have to take part?
No. Participation in the study is entirely voluntary. It is up to you to decide whether or not to do this. If you do decide to take part, we would ask you to sign a consent form and give you a copy of this information sheet and the consent form to keep. If you decide to take part you are still free to withdraw from the study at any time up until the end of February 2018. If you decide not to take part, or to withdraw, you do not have to give a reason and it will not affect your care in any way.

What are the advantages to taking part?
There are no direct advantages to you. Taking part will help improve the service offered by the MBT team at Bath NHS House in future. You might value the opportunity for people to understand your experience of treatment.

What are the disadvantages to taking part?
Questionnaires will take a short amount of time to complete (approximately 5 minutes per questionnaire), although the time for this will mostly be included in the MBT group treatment. The questionnaires that you will be asked to complete have been chosen and designed to avoid them causing any distress using feedback from people who have personal experience of receiving MBT and other treatments for 'borderline personality disorder'. However, it is possible that you might find answering questions distressing. If you find anything about your participation distressing you should let a member of your care team know, who can support you. Your care team will look at your measures regularly to help understand how your treatment is going.

How do I know that the study is properly run?
The study has been reviewed by the University of Bath Psychology Research Ethics Committee and approved as a service evaluation by Avon and Wiltshire Mental Health Partnership NHS Trust's Research and Development (R&D Department. The work of the researcher, Rebecca Sired, is supervised by Clinical Psychologists within AWP NHS Trust and the University of Bath.

Your data
All written questionnaires will remain the clinical property of AWP and kept confidential and secure in line with the Data Protection Act (1998). All data collected in this study will be anonymised before being taken outside of AWP property; no one will be able to identify you in any way from the anonymised data. The data will be used in a report to the service and may be published in a scientific journal. Upon completion of the experiment we ask you to give consent to include your data in further analyses. You are free to withdraw your data from the study up until the end of February 2018 when the project will end.

If you would like a copy of the findings of the research please contact the lead researcher, Rebecca Sired, using the email below.

Contact details
If you have any questions at any time about the study, please do not hesitate to contact us:

Researcher:
Rebecca Sired, Clinical Psychologist in Training, University of Bath Email: banestherapiesadmin@nhs.net

You can also speak to the supervisors of the project about any questions or concerns using the details below:

Service supervisor:
Dr Jennie Boland, Clinical Psychologist, AWP NHS Trust Email: banestherapiesadmin@nhs.net

Academic supervisor:
Dr Megan Wilkinson-Tough, Clinical Psychologist, University of Bath Email: M.J.Wilkinson-Tough@bath.ac.uk

If you have any concerns related to your participation in this study, please direct them to the Psychology Research Ethics Committee, via Nathalia Gjersoe (n.gjersoe@bath.ac.uk)
0117 9287841

Appendix F: SIP Consent Form

University of Bath
Department of Psychology
Tel: 01225 383251
Rebecca Sired
banestherapiesadmin@nhs.net

UNIVERSITY OF BATH

CONSENT FORM

Evaluation of Mentalisation-Based Therapy (MBT) in a secondary care service

Please answer the following questions to the best of your knowledge

	YES	NO
DO YOU CONFIRM THAT YOU:		
• are enrolled to start the MBT programme at Bath NHS House in September	☐	☐
HAVE YOU:		
• been given information explaining the study?	☐	☐
• have had an opportunity to ask questions and discuss the study?	☐	☐
• received satisfactory answers to all questions you asked?	☐	☐
• received enough information about the study for you to make a decision about your participation?	☐	☐
DO YOU UNDERSTAND: that you are free to withdraw from the study and free to withdraw your data prior to anonymisation-		
• at any time?	☐	☐
• without having to give a reason for withdrawing?	☐	☐
• that your care will be the same whether or not you decide to withdraw?	☐	☐

I hereby fully and freely consent to my participation in this study

I understand the nature and purpose of the procedures involved in this study. These have been communicated to me on the information sheet accompanying this form.

I understand and acknowledge that the investigation is designed to provide information about the service I receive and promote scientific knowledge. Avon and Wiltshire NHS Trust and the University of Bath will use the data I provide for no purpose other than service improvement and research.

I understand that the information I provide will be kept confidential and only seen by my care team and the researcher, and that my data will be anonymised by removing all links between my name or other identifying information and my study data when removed from AWP NHS Trust. This will be done by end of February 2018, and before any presentation or publication of my data. The completed measures will remain the property of AWP and used for usual clinical purposes.

I understand that the University of Bath may use the data collected for this project in a future research project but that the conditions on this form under which I have provided the data will still apply.

Participant's signature: _____ Date: _____

Name in BLOCK Letters: _____

If you have any concerns related to your participation in this study please direct them to the Department of Psychology Research Ethics Committee, via Nathalia Gjersoe Research Ethics Officer (Tel: 01225 38 3251 email: N.Gjersoe@bath.ac.uk).

Appendix G: SIP Weekly Qualitative Feedback Form

MBT Programme Weekly Feedback Form

Please circle the number which best describes how able you felt to mentalise today:

Not at all — Extremely able

1 2 3 4 5 6 7

What happened in the group today which helped you mentalise?

What could the therapist, group or you have done differently to improve your ability to mentalise?

What one thing will you take away from the group today? How will this help you or how will you apply this learning over the next week?

Over the last week *(please circle Yes or No):*

Have you been to hospital (A&E or mental health hospital)? **Yes** **No**

If yes please provide details (e.g. number of times, reason, length of stay)

Have you self-harmed over the last week? **Yes** **No**

If yes please provide details (e.g. number of episodes, how, severity compared to usual for you)

Have you attempted suicide? **Yes** **No**

If yes please provide details (e.g. number of times, how)

Appendix H: SIP Six-Monthly Qualitative Feedback Form

MBT Programme 6 month feedback form

Over the past 6 months of the MBT Programme:

What has helped you to mentalise in the group or individual sessions?

Is there anything in the group or individual sessions that made it harder for you to mentalise?

Is there anything you would change in the group or individual sessions that would improve your ability to mentalise?

Do you have any reflections on people joining the group or entering a new group? What did the therapists or group do that made it harder/easier and how would you improve this?

How have you found completing the questionnaires? Do you have any suggestions for how this process could be improved?

How do you feel about how you've been participating in the group? Is there anything the therapists, group or you do that helps or hinders your participation, or that the therapists could do to make participating easier?

Do you have any other suggestions to improve the MBT programme?

Any other comments:

Appendix I: SIP Interview Schedule

Semi-structured interview Schedule for people who drop out

- How did you find attending the MBT programme?
- I understand that you decided not to continue with MBT, can you tell me a bit about what led to this decision?
- Can you tell me about anything in the group that affected your decision to leave?
- Can you tell me about anything in the individual sessions that affected your decision to leave?
- Can you tell me about anything outside of MBT in your life that affected your decision to leave?
- Was there anything else that we haven't discussed which affected your decision to leave?
- Are there any things which the service, therapists or group could have done differently that might have meant you didn't leave the programme?
- Are there any things which you found positive or useful from the attending the MBT programme?

Appendix J: SIP Debrief Sheet

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
banestherapiesadmin@nhs.net

Evaluation of Mentalisation-Based Therapy (MBT) in a secondary care service

Participant Debrief Form

Thank you for taking part in this project which has evaluating the MBT programme at Bath NHS House. Your contribution is very much appreciated.

Background

This study measured the effectiveness of the first 6 months of the MBT programme at Bath NHS House. The aim was to help improve the MBT programme in the future. We wanted to find out when any benefits might occur the 18-month programme. We also wanted to find out more about people's experience of the MBT programme to make suggestions of ways to improve it.

Your data

All written questionnaires will remain the clinical property of AWP and kept confidential and secure in line with the Data Protection Act (1998). All data collected in this study will be anonymised before being taken outside of AWP property. The data will be stored securely for 5 years according to Good Practice Guidelines and then destroyed. You are free to withdraw your data from the study up until the end of February 2018 when the project will end.

If you would like to receive a summary of the results, please contact Rebecca Sired using the email below. These results will be shared with the MBT team at Bath NHS House. Our results may eventually be published in a scientific journal, and may also be reported at scientific meetings. No one will able to identify you in these reports.

Useful Readings

If you are interested in finding out more information about the evidence base for MBT, please see the following resources:

- Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. American Journal of Psychiatry, 166(12), 1355-1364.
- Bateman, A., & Fonagy, P. (2016). Mentalization-based treatment for personality disorders: A practical guide: Oxford University Press.

If you have any concerns related to your participation in this study please direct them to the Department of Psychology Research Ethics Committee, via Nathalia Gjersoe, Psychology Research Ethics Officer (Tel: 01225 38 3251 email: N.Gjersoe@bath.ac.uk).

Appendix K: British Journal of Clinical Psychology Author Guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/bjcp

Click here for more details on how to use **Editorial Manager**.

All papers published in the *British Journal of Clinical Psychology* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Preprint policy:

This journal will consider for review articles previously available as preprints on non-commercial servers such as ArXiv, bioRxiv, psyArXiv, SocArXiv, engrXiv, etc. Authors may also post the submitted version of a manuscript to non-commercial servers at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, please view the **Author Guidelines**.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Articles should be no more than 5000 words (excluding the abstract, reference list, tables and figures) and any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered.

4. PREPARING THE SUBMISSION

Contributions must be typed in double spacing. All sheets must be numbered.

Cover Letters

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);

ii. A short running title of less than 40 characters;

iii. The full names of the authors;

iv. The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;

v. Abstract;

vi. Keywords;

vii. Practitioner Points;

viii. Acknowledgments.

Authorship

Please refer to the journal’s Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

Please provide a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Please provide appropriate keywords.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice. (Please include the 'Practitioner Points' in your main document but do not submit them to Editorial Manager with your abstract.)

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Main Text File

As papers are dou target="_blank"le-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

i. Title

ii. Main text

iii. References

iv. Tables and figures (each complete with title and footnotes)

v. Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should

be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Colour figures. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.

- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here.** In particular, we encourage authors to consult Wiley's best practice tips on **Writing for Search Engine Optimization**.

Editing, Translation, and Formatting Support: **Wiley Editing Services** can greatly improve the chances of a manuscript being accepted. Offering expert help in English language editing, translation, manuscript formatting, and figure preparation, Wiley Editing Services ensures that the manuscript is ready for submission.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. The **qualitative guidelines** explain how the quality of research papers using qualitative methods will be judged. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in '**What happens to my paper?**' Appeals are handled according to the **procedure recommended by COPE**. Wiley's policy on the confidentiality of the review process is **available here**.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues

- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)

Data Sharing and Data Accessibility

The *British Journal of Clinical Psychology* recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, please access the **FAQs**for additional detail.

Publication Ethics

This journal is a member of the **Committee on Publication Ethics (COPE)**. Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found **here**.

ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. **Find more information here.**

6. AUTHOR LICENSING

If a paper is accepted for publication, the author identified as the formal corresponding author will receive an email prompting them to log in to Author Services, where via the Wiley Author Licensing Service (WALS) they will be required to complete a copyright license agreement on behalf of all authors of the paper.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **OnlineOpen** under the terms of a Creative Commons License.

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under OnlineOpen, please **click here.** (Note that certain funders mandate a particular type of CC license be used; to check this please click **here**.)

BPS members:

Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. Please click **here** for more detailed information about self-archiving definitions and policies.

Open Access fees**:** Authors who choose to publish using OnlineOpen will be charged a fee. A list of Article Publication Charges for Wiley journals is available **here.**

Funder Open Access**:** Please click **here** for more information on Wiley's compliance with specific Funder Open Access Policies.

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Article Received in Production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. The author will be asked to sign a publication license at this point.

Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Publication Charges

Colour figures. Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures, they will be sent a Colour Work Agreement once the accepted paper moves to the production process. If the Colour Work Agreement is not returned by the specified date, figures will be converted to black and white for print publication.

Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with **Wiley Author Services**). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).

- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

Promoting the Article

To find out how to best promote an article, click **here**.

Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Vicki Pang, Senior Editorial Assistant (**bjc@wiley.com**) or phone +44 (0)1243 770 410.

Author Guidelines updated 10th April 2019

Appendix L: MRP Health Research Authority Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Rebecca Sired
University of Bath, Department of Psychology, 10 West
Claverton Down
Bath
BA27AY

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

19 November 2018

Dear Miss Sired

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Catastrophic interpretation of possible symptoms in people in recovery from psychosis or anxiety disorders; association with fear of relapse and mental health anxiety**
IRAS project ID:	**241705**
Protocol number:	**N/A**
REC reference:	**18/SC/0522**
Sponsor	**University of Bath**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

Appendix M: MRP University of Bath Ethics Approval

PREC 18-306

psychology-ethics

Wed 21/11/2018 08:42

To:Rebecca Sired <R.Sired@bath.ac.uk>;

Cc:Emma Griffith <E.J.Griffith@bath.ac.uk>;

Dear Rebecca

Ethics code: PREC 18-306
Full title of study Catastrophic interpretation of possible symptoms in people in recovery from psychosis or anxiety disorders; association with fear of relapse and mental hea

I am happy to confirm that you have received full ethical approval from the University of Bath Department of Psychology Research Ethics Committee for your application. In light of the fact that this project has no serious ethical concerns, this approval has been granted via Chair's Action. Please use the code 18-306 as proof of ethical approval on internal documentation.
Please be aware that it is your responsibility to let us know as soon as possible if any issues or complaints of an ethical nature arise over the course of your research.

Best of luck with your research,

Dr. Jie Sui
Chair, Psychology Research Ethics Committee

UNIVERSITY OF BATH

Rebecca Wise, DC (Research Ethics)
PREC wiki: https://wiki.bath.ac.uk/display/PEC/Psychology+Research+Ethics+Committee+Home
REACH wiki:
https://wiki.bath.ac.uk/display/DfHealthREACH/Research+Ethics+Approval+Committee+for+Health+%28REACH%29+Home
SSREC wiki: https://wiki.bath.ac.uk/display/SSREC/Social+Science+Research+Ethics+Committee+%28SSREC%29+Home
10 West 1.05, Department of Psychology, Bath BA2 7AY, United Kingdom
Telephone: +44 (0)1225 384714

Appendix N: MRP AWP and 2gether Trusts Research and Development Approval

AWP R&D confirmation - 1069AWP

Shovelton, Claire <Claire.Shovelton@awp.nhs.uk>

Thu 29/11/2018 09:35

To: Rebecca Sired <R.Sired@bath.ac.uk>;

Cc: Emma Griffith <E.J.Griffith@bath.ac.uk>; Pro-Vice-Chancellor for Research <pro-vc-research@bath.ac.uk>; ANTONIADES, Hannah (AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST) <hannah.antoniades@nhs.net>; NOONAN, Krist (AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST) <krist.noonan@nhs.net>; GOODFELLOW, Thomas (AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST) <thomas.goodfellow@nhs.net>;

6 attachments (3 MB)

AWP Logo.docx; RiO use in Research v6.5 Feb2017.pdf; AWP EDGE Non-NIHR Guide v3 Aug2017.pdf; AWP EDGE Researcher FAQs v2.pdf; 241705_PIC sites_SOA_Assessed by HRA.docx; 241705_PIC sites_SOE_Assessed by HRA.xls;

Dear Rebecca,

Title of study: Catastrophic interpretation of possible symptoms in people in recovery from psychosis or anxiety disorders; association with fear of relapse and mental health anxiety
AWP ref: 1069AWP
R&D confirmation date: 29th November 2018
Recruitment end date: 30th September 2019
Study end date: 30th September 2019
Clinical Teams for which confirmation granted: Early Intervention in Psychosis, IAPT services, Recovery, Rehabilitation and Community Mental Health Teams

Thank you very much for applying to undertake your research in AWP, we pride ourselves on a straight forward and rapid process for research governance.

We are pleased to advise we are able to grant R&D Confirmation at Avon and Wiltshire Mental Health Partnership NHS Trust ("the Trust") to cover the locations as stated above. Please find attached the AWP logo to use on any local documents you will be issuing i.e. information sheets and consent forms.

Interpretation of experience sin recovery from psychosis or anxiety v1 - 18/027/2GT

WALKER, Mark (2GETHER NHS FOUNDATION TRUST) <mark.walker9@nhs.net>

Mon 10/12/2018 16:56

Inbox

To:Rebecca Sired <rs2176@bath.ac.uk>;

Cc:Burrage Alex <Alex.Burrage@glos.nhs.uk>; HOOPER, Donna (2GETHER NHS FOUNDATION TRUST) <donna.hooper2@nhs.net>;

Dear Rebecca

Re: Catastrophic interpretation of possible symptoms in people in recovery from psychosis or anxiety disorders: association with fear of relapse and mental health anxiety
IRAS: 241705
Local R&D: 18/027/2GT

Thank you for sending me full details of your project. This email confirms capacity and capability on behalf of 2gether NHS Foundation trust for the above study. This approval is given on the basis of our discussions around the support that Alex Burrage and her team is able to provide. If you need any further support in the future, please let me know as soon as possible.

Best of luck with the project

Kind regards

Mark

Mark Walker
Head of Research and Development
Research [2]gether

Fritchie Centre, Charlton Lane, Cheltenham, GLOS GL53 9DZ

T: 01242 634490 **D:** 01242 634491 **M:** 07790555299 **E:** mark.walker9@nhs.net
www.2gether.nhs.uk

Appendix O: MRP Information Sheet

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
V3: 09/11/18
IRAS ID: 241705

Participant Information Sheet: Interpretation of experiences in recovery from psychosis or anxiety

We would like to invite you to take part in our research project. Before you decide whether to take part, it is important for you to understand why this research is being done and what it would involve. Please read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the project?

This project aims to understand more about when mental health problems might be seeming to reoccur (having a relapse) in people who are in recovery. To do this we want to find out what people would think if they had particular experiences where there could be different explanations for what is happening.

We are interested in whether having previous personal experience of particular mental health problems makes a difference to what people would think in these situations. We will do this by comparing the responses of people with and without experience of mental health problems. We are also investigating whether people who have recovered from a mental health problem worry about their mental health problem coming back.

Who can take part?

We would like to get the thoughts of people 18 and over from these 3 groups who:

1. consider themselves *in recovery from psychosis*
2. consider themselves *in recovery from an anxiety disorder* (Generalised Anxiety Disorder/worry, OCD, Social Anxiety or Panic Disorder/Agoraphobia)
3. have *no experience of mental health difficulties.*

Do I have to take part?

No, taking part is completely voluntary. You have the right to withdraw from the project at any point during the study without giving a reason. As the data collected is anonymous you will be unable to withdraw your data once you complete the study.

What will happen to me if I do decide to take part?

You will be asked to complete a consent form to say you are happy to take part. You will then be asked to complete a questionnaire pack which will include some questions about your mental health. This will take approximately 30-40 minutes to fill in.

The questionnaire pack can be completed either online or sent to you to complete at home and return in a freepost envelope.

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
V3: 09/11/18
IRAS ID: 241705

At the end of questionnaire pack you will be asked if you would be happy for us to contact you in around two weeks about the second part of the study. This is completely optional. The second part involves completing one of the questionnaires again, which will take roughly 10 minutes.

What are the benefits of taking part?

We cannot promise that the project will help you directly, but the information collected from you and other participants may help improve our understanding of mental health relapse. We hope that these results will inform how professionals support people with experience of mental health problems such as psychosis and anxiety disorders in order to reduce relapse.

We will also make a £2 donation to your choice of a selection of mental health charities in acknowledgement of your time and contribution.

Are there any disadvantages/risks from taking part?

Taking part will take approximately 30-40 minutes of your time. If you opt-in to the second part of the study this will take around 10 minutes more. Apart from this we think that there are few disadvantages to taking part. The questionnaires have been chosen/designed with feedback from people with personal experience of psychosis and anxiety disorders to minimise the potential for completing them to cause distress. However, it is possible that you might find answering the questions distressing. You can stop completing the study at any time if this is the case. At the end of the study (or if you withdraw at any point during completion) you will be provided with contact details of services and third-party organisations that would be able to offer support and guidance if you experience any distress.

The study has been approved by the University of Bath Ethics Committee (ref: PREC 18-306) and the Health Research Authority (ref: 241704).

What happens with my information?

The questionnaire data that we collect is anonymous. That means that your questionnaire data is not linked with any information that could identify you, and we do not collect information such as your name or date of birth. If you choose to complete a paper copy of the questionnaires by post you will be asked to provide your address to the researcher for this purpose. If you chose to opt-in to be contacted about the second part of the study you will be asked to provide your email address for this purpose. Any addresses would be kept on a password protected computer file. These will be deleted once the questionnaire pack has been posted/ once the email invitation to the second part of the study is sent. Your postal or email address will not be linked to any of your completed data. Electronic reports will be kept on password protected computers. Paper records will be kept in a locked cabinet which is only accessible by the researcher and the research supervisors.

We will report our findings in academic journals and present them to relevant health professionals at meetings and conferences. The findings will also contribute to Rebecca

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk

Sired's Doctorate in Clinical Psychology. You will not be identified in any reports or publications arising from the study. If you would like to receive a copy of the results, please email the researcher who can send them to you on completion.

The University of Bath is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at: https://www.bath.ac.uk/guides/data-protection-guidance/.

AWP/2gether NHS Trust will collect information from you and/or your medical records for this research study in accordance with our instructions. AWP/2gether NHS Trust will keep your name and contact details confidential and will not pass this information to University of Bath. AWP/2gether will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from University of Bath and regulatory organisations may look at your medical and research records to check the accuracy of the research study. University of Bath will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

What if there is a problem?

If you have any concerns or wish to complain about any aspect of this project, you should initially contact the researcher (Rebecca Sired) or one of her supervisors, who will do their best to address your concerns. Her contact details are provided at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the University of Bath Secretary Mark Humphriss on 01225 386212 or universitysec@bath.ac.uk.

Every care has been taken to ensure your safety during the course of the study. The University of Bath, as Sponsor of the study, has indemnity (insurance) arrangements in place but we anticipate that being part of the study will be a positive experience.

I'm interested in taking part, what next?

If you would like to participate please go to this website to take part:
https://tinyurl.com/yamjvz6h

Appendix P: MRP Consent Form

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
V4: 15/11/18
IRAS ID: 241705

Participant Identification Number:

CONSENT FORM

You have been invited to take part in a study exploring how people in recovery from psychosis or anxiety disorders interpret different experiences compared to people without previous mental health difficulties, and people's thoughts about their mental health. This form is to seek your consent to take part in the study.

Title of Project: Interpretation of experiences in recovery from psychosis or anxiety

Name of Researcher: Rebecca Sired, Clinical Psychologist in Training at the University of Bath

Supervisors: Dr Emma Griffith (University of Bath), Prof Paul Salkovskis (University of Oxford), Dr Taruna Jamalamdaka (Clinical Psychologist, 2gether Trust), Dr Kate Chapman (Clinical Psychologist, AWP)

	Please tick all boxes
1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the data collection until I submit my responses.	☐
3. I understand that as the study is anonymous and I will be unable to withdraw my data once I submit my data at the end of the study.	☐
4. I understand that my data will be stored securely in line with the General Data Protection Regulation (2018) and that data collected will be anonymous so that no information that could identify me will be collected.	☐
5. I agree to my anonymous data, including any quotes, being used in presentations and publications of the research.	☐
6. I understand that the University of Bath may use the data collected for this project in a future research project but that the conditions on this form under which I have provided the data will still apply.	☐
7. I agree to take part in the above study.	☐

Appendix Q: MRP Questionnaire Pack

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
V1: 27/04/18
IRAS ID: 241705

Demographic information

Please answer the following questions by ticking one response or completing the blank space provided:

1. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Gender non-conforming
- ☐ Prefer not to say

2. What is your age?

..... years (please complete)

3. What is your ethnic group?

- ☐ Asian
- ☐ Black
- ☐ Caucasian
- ☐ Mixed background
- ☐ Prefer not to say
- Other: .....

4. What is your highest level of education?

- ☐ o formal education
- ☐ Primary
- ☐ Secondary (GCSE's, O levels)
- ☐ A levels
- ☐ Diploma (or professional qualification)
- ☐ Undergraduate Degree
- ☐ Postgraduate degree
- ☐ PhD
- ☐ Prefer not to say
- Other: .....

5. What is your relationship status?

- ☐ Single
- ☐ In a relationship
- ☐ Co-habiting
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer not to say
- Other: .....

6. What is your employment situation? (please tick all that apply)

- ☐ Paid work
- ☐ Voluntary work
- ☐ Student
- ☐ On sick leave
- ☐ Homemaker
- ☐ Unemployed
- ☐ Prefer not to say
- Other: .....

Your mental health

1. Have you ever experienced a mental health problem for which you received a diagnosis or treatment?

Yes No (If No please go to question 8)

2. What was/is your main mental health problem? (please tick one of the below)

- ☐ Psychosis

Please indicate your diagnosis if you have/had one:

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
V1: 27/04/18
IRAS ID: 241705

- ☐ Schizophrenia
- ☐ First episode psychosis
- ☐ Delusional disorder
- ☐ Schizoaffective disorder
- ☐ Psychotic depression
- ☐ Bipolar with psychotic features
- ☐ Brief psychotic disorder
- ☐ Schizophreniform disorder
- ☐ Other mental health problem which psychosis was part of (please specify): .....

☐ Anxiety disorder

Please indicate your diagnosis if you have/had one:

- ☐ Obsessive-Compulsive disorder (OCD)
- ☐ Generalised Anxiety disorder (GAD or worry)
- ☐ Social Anxiety/ Social Phobia
- ☐ Panic disorder (with or without Agoraphobia)

☐ Other (including Health Anxiety/ Illness Anxiety disorder, Substance misuse, Learning Disability)

3. How many episodes of this mental health problem have you experienced?

.....

4. Have you experienced any other mental health problems for which you received a diagnosis or treatment? If yes, please specify:

.....

5. Would you say you have been able to build a life beyond your main mental health problem (even if all your symptoms haven't disappeared)? (please circle one)

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Neutral	Mildly Agree	Moderately Agree	Agree	Strongly Agree
1	2	3	4	5	6	7	8	9

6. Compared to the worst your symptoms have been, how would you rate the severity of your current symptoms of your main mental health problem, if any?

No symptoms	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
1	2	3	4	5	6	7

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
V1: 27/04/18
IRAS ID: 241705

7. Have you received any treatment for your main mental health problem?

☐ No ☐ Yes

Please tick all that apply:

- ☐ Cognitive behavioural therapy (CBT)
- ☐ Secondary care support (e.g. Community Mental Health team, Recovery team, Early Intervention team)
- ☐ Medication
- ☐ Family therapy
- ☐ Voluntary inpatient admission to mental health hospital
- ☐ Non-voluntary inpatient admission to mental health hospital (under section of the Mental Health Act)
- ☐ Other psychological therapy: .....
- ☐ Other treatment: .....

8. How did you hear about the study?

- ☐ Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- ☐ 2gether NHS Foundation Trust
- ☐ Internet (social media, forum etc.)
- ☐ Poster
- ☐ Other: .....

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
IRAS ID: 241705

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. feeling afraid as if something awful might happen	0	1	2	3

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
IRAS ID: 241705

UNIVERSITY OF BATH

Patient Health Questionnaire—PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
*9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

*If you scored 1 or above on item 9 this suggests that you may be feeling distressed at the moment or have been experiencing distress over the last two weeks. You may find it helpful to contact your GP for advice or support, or other sources of emotional support such as the Samaritans (116 123). If you are receiving support from mental health services, you can also contact your care co-ordinator or your local crisis team.

You may also want to consider whether you are feeling emotionally resilient enough to take part in the study right now. Remember that you can withdraw from the study at any point.

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
IRAS ID: 241705

work and social adjustment scale (w&sas)

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your mental health problem impairs your ability to carry out the activity (please circle your answer)

1.) **work** – *if you are retired or choose not to have a job for reasons unrelated to your problem, please tick here* ☐

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely I cannot work

2.) **home management** – cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

3.) **social leisure activities** – with other people, e.g. parties, pubs, outings, entertaining etc

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

4.) **private leisure activities** – done alone, e.g. reading, gardening, sewing, hobbies, walking etc

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

5.) **family and relationships** – form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
IRAS ID: 241705

work and social adjustment scale (w&sas) 2

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your mental health problem impaired your ability to carry out the activity ***when your main mental health problem was at its worst*** *(please circle your answer)*

1.) **work** – *if you are retired or choose not to have a job for reasons unrelated to your problem, please tick here* ☐

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely I cannot work

2.) **home management** – cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

3.) **social leisure activities** – with other people, e.g. parties, pubs, outings, entertaining etc

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

4.) **private leisure activities** – done alone, e.g. reading, gardening, sewing, hobbies, walking etc

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

5.) **family and relationships** – form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely

ReQoL™
Recovering Quality of Life

The University Of Sheffield.

For each of the following statements, please tick one box that best describes your thoughts, feelings and activities **over the last week**.

Over the last week	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1. I found it difficult to get started with everyday tasks	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. I felt able to trust others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. I felt unable to cope	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. I could do the things I wanted to do	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I felt happy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I thought my life was not worth living	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7. I enjoyed what I did	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I felt hopeful about my future	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I felt lonely	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10. I felt confident in myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

	No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
Please describe your **physical** health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) **over the last week**	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

For official use

ReQoL-10 Score = ...

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
IRAS ID: 241705

Mental Health Anxiety Inventory

Each question in this section consists of a group of four statements. Please read each group of statements carefully and then select the one that best describes your feelings about your mental well being **over the past 6 months**.

Identify the statement by ticking the box next to it; it may be that more than one statement applies, in which case, please tick any that are applicable. **Please answer all questions.**

Please be aware that for the purpose of this survey the terms "**mental**" and "**psychological**" mean the same thing.

1.

☐ I do not worry about my mental health.

☐ I occasionally worry about my mental health.

☐ I spend much of my time worrying about my mental health.

☐ I spend most of my time worrying about my mental health.

2.

☐ I notice unusual changes in my mental state less than most other people (Of my age).

☐ I notice unusual changes in my mental state as much as most other people (Of my age).

☐ I notice unusual changes in my mental state more than most other people (Of my age).

☐ I am aware of unusual changes in my mental state all the time.

3.

☐ As a rule I am not aware of unusual things happening in my mind.

☐ Sometimes I am aware of unusual things happening in my mind.

☐ I am often aware of unusual things happening in my mind.

☐ I am constantly aware of unusual things happening in my mind.

4.

☐ Resisting thoughts of mental illness is never a problem.

☐ Most of the time I can resist thoughts of mental illness.

☐ I try to resist thoughts of mental illness but am often unable to do so.

☐ Thoughts of mental illness are so strong that I no longer even try to resist them.

5.

☐ As a rule I am not afraid that I have a serious mental illness.

☐ I am sometimes afraid that I have a serious mental illness.

☐ I am often afraid that I have a serious mental illness.

☐ I am always afraid that I have a serious mental illness.

6.

☐ I do not have images (mental pictures) of myself being mentally ill.

☐ I occasionally have images of myself being mentally ill.

☐ I frequently have images of myself being mentally ill.

☐ I constantly have images of myself being mentally ill.

7.

☐ I do not have any difficulty taking my mind off thoughts about my mental health.

☐ I sometimes have difficulty taking my mind off thoughts about my mental health.

☐ I often have difficulty in taking my mind off thoughts about my mental health.

☐ Nothing can take my mind off thoughts about my mental health.

8.

☐ I am lastingly relieved if my doctor or mental health professional tells me there is nothing wrong.

☐ I am initially relieved but the worries sometimes return later.

☐ I am initially relieved but the worries always return later.

☐ I am not relieved if my doctor or mental health professional tells me there is nothing wrong.

9.

☐ If I hear about a mental illness I never think I have it myself.

☐ If I hear about a mental illness I sometimes think I have it myself.

☐ If I hear about a mental illness I often think I have it myself.

☐ If I hear about a mental illness I always think I have it myself.

10.

☐ If I experience an unexpected mental event I rarely wonder what it means.

☐ If I experience an unexpected mental event I often wonder what it means.

☐ If I experience an unexpected mental event I always wonder what it means.

☐ If I experience an unexpected mental event I must know what it means.

11.

☐ I usually feel at very low risk for developing a serious mental illness.

☐ I usually feel at fairly low risk for developing a serious mental illness.

☐ I usually feel at moderate risk for developing a serious mental illness.

☐ I usually feel at high risk for developing a serious mental illness.

12.

☐ I never think I have a serious mental illness.

☐ I sometimes think I have a serious mental illness.

☐ I often think I have a serious mental illness.

☐ I usually think that I am seriously mentally ill.

13.

☐ If I notice an unexplained psychological sensation I don't find it difficult to think about other things.

☐ If I notice an unexplained psychological sensation I sometimes find it difficult to think about other things.

☐ If I notice an unexplained psychological sensation I often find it difficult to think about other things.

☐ If I notice an unexplained psychological sensation I always find it difficult to think about other things.

14.

☐ My family and friends would say I do not worry enough about my mental health.

☐ My family and friends would say I have a normal attitude to my mental health.

☐ My family and friends would say I worry too much about my mental health.

☐ My family and friends would say I am a hypochondriac.

For the following questions, **please think about what it might be like if you had a serious mental illness of a type that particularly concerns you** (for e.g. schizophrenia, bi-polar, and so on). Obviously you cannot know for definite what it would be like; please give your best estimate of what you think might happen, basing your estimate on what you know about yourself and serious mental illness in general.

15.

☐ If I had a serious mental illness I would still be able to enjoy things in my life quite a lot.

☐ If I had a serious mental illness I would still be able to enjoy things in my life a little.

☐ If I had a serious mental illness I would be almost completely unable to enjoy things in my life.

☐ If I had a serious mental illness I would be completely unable to enjoy life at all.

16.

☐ If I developed a serious mental illness there is a good chance that modern medicine would be able to cure me.

☐ If I developed a serious mental illness there is a moderate chance that modern medicine would be able to cure me.

☐ If I developed a serious mental illness there is a very small chance that modern medicine would be able to cure me.

☐ If I developed a serious mental illness there is no chance that modern medicine would be able to cure me.

17.

☐ A serious mental illness would ruin some aspects of my life.

☐ A serious mental illness would ruin many aspects of my life.

☐ A serious mental illness would ruin almost every aspect of my life.

☐ A serious mental illness would ruin every aspect of my life.

18.

☐ If I had a serious mental illness I would not feel that I had lost my dignity.

☐ If I had a serious mental illness I would feel that I had lost a little of my dignity.

☐ If I had a serious mental illness I would feel that I had lost quite a lot of my dignity.

☐ If I had a serious mental illness I would feel that I had totally lost my dignity.

University of Bath
Department of Psychology
Tel: 01225 38 3251
Rebecca Sired
r.sired@bath.ac.uk
IRAS ID: 241705

UNIVERSITY OF BATH

Fear of Recurrence Scale

This section is concerned with problems and complaints people sometimes have. Please read each item carefully and select the appropriate option that best describes how you have been **over the last two weeks including today**.

	Do not agree (1)	Agree slightly (2)	Agree moderately (3)	Agree very much (4)
I have been worrying about relapse.	☐	☐	☐	☐
I have been remembering previous episodes of being unwell.	☐	☐	☐	☐
I have been more aware of my thoughts.	☐	☐	☐	☐
I have experienced thoughts intruding into my mind.	☐	☐	☐	☐
I have been worrying about my thoughts.	☐	☐	☐	☐
I have felt unable to control my illness.	☐	☐	☐	☐
I have been worrying about being in hospital.	☐	☐	☐	☐
I have lacked confidence in my ability to cope.	☐	☐	☐	☐
My thoughts have been uncontrollable.	☐	☐	☐	☐
My thoughts have been going too fast.	☐	☐	☐	☐
I have been worrying about losing control.	☐	☐	☐	☐
	Do not agree (1)	Agree slightly (2)	Agree moderately (3)	Agree very much (4)

	Do not agree (1)	Agree slightly (2)	Agree moderately (3)	Agree very much (4)
My thoughts have been distressing.	☐	☐	☐	☐
I have felt more in touch with my thoughts.	☐	☐	☐	☐
I have been constantly aware of my thoughts.	☐	☐	☐	☐
I have been unable to switch off my thinking.	☐	☐	☐	☐
I have paid close attention to how my mind is working.	☐	☐	☐	☐
The world has seemed more vivid and colourful.	☐	☐	☐	☐
My thoughts have been more interesting.	☐	☐	☐	☐
I have had new insights and ideas.	☐	☐	☐	☐
Unpleasant thoughts have entered my head against my will.	☐	☐	☐	☐
My thinking has been clearer than usual.	☐	☐	☐	☐
I have been checking my thoughts.	☐	☐	☐	☐
The thought of becoming unwell has frightened me.	☐	☐	☐	☐
	Do not agree (1)	Agree slightly (2)	Agree moderately (3)	Agree very much (4)

Appendix R: MRP Experiences Interpretation Questionnaire

Experiences Interpretation Questionnaire (EIQ)

Here are some brief descriptions of situations in which it is not quite clear what is happening. Read each one and then answer the question below it very briefly. Write down the first thing that comes into your mind without thinking too long about it. Please write down what you think is happening before you go to the next page. Be as specific as possible.

When you have done that, go to the next page and you will see four possible explanations for the situation. Rank these in the order in which they would be ***most likely*** *to come to mind if you found yourself in a similar situation. So the one you would consider* ***most likely*** *to come to mind should be ranked as 1, and the one you would consider* ***least likely*** *to come to mind should be ranked as 4. Do not think too long before deciding. We want your first impressions, and do not worry if none of them fits with what you actually did think.*

Example item: You come home and notice your front door is ajar

Why? …

I went out in a rush this morning and left the door slightly open by accident

a) Someone with a key has come to visit

b) I didn't close it properly

c) There is a burglar in the house

d) There is something wrong with the handle mechanism

1st …. b 2nd…. c 3rd…. d 4th…. a

1. You have a missed call from your bank

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

1. You have a missed call from your bank

Why?

a) They want to offer me a loyalty reward

b) They have a query about a payment

c) I have been the victim of fraud

d) It was a sales call

1st …. 2nd…. 3rd…. 4th….

2. You have the idea that the person you are with can hear or read your thoughts

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

2. You have the idea that the person you are with can hear or read your thoughts

Why?

a) I am under a lot of stress at the moment

b) We are both thinking along very similar lines

c) I didn't sleep well last night

d) I am mentally falling apart

1st …. 2nd…. 3rd…. 4th….

3. You notice that your body feels very tense

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

3. You notice that your body feels very tense

Why?

a) I am heading towards a mental breakdown

b) I haven't been taking enough care of myself recently

c) I need to spend more time relaxing

d) I am ready for action

1st …. 2nd …. 3rd …. 4th ….

4. An unacceptable thought pops into your mind

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

4. An unacceptable thought pops into your mind

Why?

a) Because everyone has random thoughts sometimes

b) This is how my mind works when I am being creative

c) My mental state is getting worse

d) There's a lot going on in my life right now

1st …. 2nd…. 3rd…. 4th….

5. You experience a sudden rush of anxiety

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

5. You experience a sudden rush of anxiety

Why?

a) My body is letting me know that I need to slow down

b) I just remembered an urgent task that I had forgotten to complete

c) I am too tired

d) I am becoming mentally unwell

1st …. 2nd…. 3rd…. 4th….

6. You hear a voice in the corner of the room say your name when nobody is there

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

6. You hear a voice in the corner of the room say your name when nobody is there

Why?

a) I am losing my grip on reality

b) I have been spending too much time alone

c) My body is telling me that I need to get more sleep

d) I misheard an everyday noise

1st …. 2nd…. 3rd…. 4th….

7. You start sweating a lot in a social situation

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

7. You start sweating a lot in a social situation

Why?

a) The room is very crowded

b) I am wearing too much clothing

c) I am becoming overwhelmed with anxiety

d) My body is reacting to my desire to make a good impression on people

1st …. 2nd…. 3rd…. 4th….

8. A letter marked 'Urgent' arrives.

What is in the letter?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

8. A letter marked 'Urgent' arrives.

What is in the letter?

a) I've won a prize

b) It is junk mail designed to attract my attention

c) It is news that I or someone I know has a serious illness

d) I forgot to pay a bill

1st …. 2nd…. 3rd…. 4th….

9. You notice your thoughts jumping randomly from one topic to another

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

9. You notice your thoughts jumping randomly from one topic to another

Why?

a) I have a lot on my mind at the moment

b) I am becoming mentally unwell

c) I need to take more time out for myself

d) I am feeling creative right now

1st …. 2nd …. 3rd …. 4th ….

10. You are lying in bed and hear a noise downstairs

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

10. You are lying in bed and hear a noise downstairs

Why?

a) There is a burglar in the house

b) Something fell off a shelf

c) It's the pipes as the heating has come on

d) A neighbour or someone I live with is moving around

1st …. 2nd…. 3rd…. 4th….

11. You are watching TV and have the idea that the news item has particular meaning or significance to you

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

11. You are watching TV and have the idea that the news item has particular meaning or significance to you

Why?

a) I am going mad

b) It is a coincidence as I was thinking about something similar earlier that day

c) I am tired and these things can happen

d) This is a sign I need to take more care of myself

1st …. 2nd …. 3rd …. 4th ….

12. You have a thought that doesn't seem like your own

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

12. You have a thought that doesn't seem like your own

Why?

a) I am going crazy

b) I have not been sleeping well

c) I have a lot on in my life at the moment and need a break

d) I am feeling imaginative today and occasionally have unusual thoughts when I feel this way

1st …. 2nd…. 3rd…. 4th….

13. You hear a loud shriek

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

13. You hear a loud shriek

Why?

a) Someone stubbed their toe

b) Someone has had an exciting surprise

c) It was an animal

d) Someone is being attacked

1st …. 2nd…. 3rd…. 4th….

14. There is a knock on the door

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

14. There is a knock on the door

Why?

a) Someone I know is paying me a visit

b) A neighbour wants to ask me something

c) The police have come to tell me bad news

d) It's a delivery

1st …. 2nd…. 3rd…. 4th….

15. You notice people looking at you as you walk down the street and have the thought that they are out to get you

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

15. You notice people looking at you as you walk down the street and have the thought that they are out to get you

Why?

a) Things in my life are difficult or uncertain at the moment

b) My mental health is beginning to spiral out of control

c) I've been exposed to something frightening recently e.g. a scary film or story

d) I have a lot on currently and am feeling understandably sensitive

1st …. 2nd …. 3rd …. 4th ….

16. You notice your heart is beating quickly and pounding

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

16. You notice your heart is beating quickly and pounding

Why?

a) I am feeling excited

b) I have been physically active

c) My mind is spiralling out of control

d) I have had too much caffeine

1st …. 2nd…. 3rd…. 4th….

17. A member of your family is late arriving home

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

17. A member of your family is late arriving home

Why?

a) They have had a serious accident on the way home

b) They have stopped for some shopping

c) Their journey is taking longer than usual

d) They met a friend and are talking with them

1st …. 2nd…. 3rd…. 4th….

18. You notice that your heart is pounding, you feel breathless, dizzy and unreal

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

18. You notice that your heart is pounding, you feel breathless, dizzy and unreal

Why?

a) I have been overdoing it and am overtired

b) I am getting a cold

c) I am losing control of my mind

d) I am feeling enthusiastic about something

1st …. 2nd…. 3rd…. 4th….

19. You have the thought that if you don't check things a certain number of times something terrible will happen

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

19. You have the thought that if you don't check things a certain number of times something terrible will happen

Why?

a) I am daydreaming/my mind is wandering

b) I am under a lot of pressure at the moment

c) I am starting to lose grasp of myself

d) I am a careful person

1st …. 2nd…. 3rd…. 4th….

20. You smell smoke

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

20. You smell smoke

Why?

a) The neighbours are having a barbecue

b) My house is on fire

c) Someone is smoking a cigarette

d) Some food is burning

1st …. 2nd…. 3rd…. 4th….

21. You have the idea that you have a special mission in life

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

21. You have the idea that you have a special mission in life

Why?

a) I value having something important to do

b) I am daydreaming

c) I am feeling drained and need some time out

d) I am going out of my mind

1st …. 2nd…. 3rd…. 4th….

22. You are walking outside and hear a big bang

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

22. You are walking outside and hear a big bang

Why?

a) Someone dropped something heavy

b) There has been an explosion or a shooting

c) Someone let off a firework

d) A car just backfired

1st …. 2nd…. 3rd…. 4th….

23. You are lying in bed alone and have the sense there is someone else in the room

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

23. You are lying in bed alone and have the sense there is someone else in the room

Why?

a) Something difficult in my life at the moment is affecting me

b) I am losing my mind

c) I need to get some more sleep and I'll feel fine

d) I am not yet fully awake

1st …. 2nd…. 3rd…. 4th….

24. You notice that you are flooded by worries

Why?

……

Rank these explanations in the order from 1 (**most likely** to come to mind) to 4 (**least likely** to come to mind).

24. You notice that you are flooded by worries

Why?

a) I care a lot about people and events and worrying is normal for me

b) I am worn out and need a break

c) I've not been getting enough support with what's going on for me

d) I am developing a mental health problem

1st …. 2nd …. 3rd …. 4th ….

Appendix S: MRP Debrief Sheet

University of Bath
Department of Psychology
Tel: 01225 383251
Rebecca Sired
r.sired@bath.ac.uk
V2: 26/10/18
IRAS ID: 241705

Study Debrief

Many thanks for taking part in this study, your time is very much appreciated.

In recognition of your contribution we would like to make a £2 donation to a mental health charity. Please select one of the below charities:

- ☐ **Rethink**: A charity that believes a better life is possible for the millions of people affected by mental Illness.
- ☐ **National Hearing Voices Network**: A charity that is committed to helping people who hear voices.
- ☐ **OCDUK**: A national OCD charity, run by and for people with lived experience of OCD.
- ☐ **Anxiety UK**: A charity provide support and help to those living with anxiety conditions.

Main questions of the study

Experiencing mental health problems can be very distressing. People who have previously experienced psychosis are understandably often afraid of experiencing it again (often referred to as a relapse). Research has found that people in recovery from psychosis who are more afraid of relapsing can be more likely to actually have a relapse. However, we do not currently know why this is.

Some psychological theories suggest that it is the meaning people make of their experiences which leads to distress, rather than the experience itself. This study is exploring whether people in recovery from psychosis would think the worst (catastrophise) when asked to imagine having experiences which could be symptoms of psychosis, and would take them to mean they are going to have a relapse. This is important to know as this might understandably make people feel more anxious, which could in turn make their mental health problem worse and lead to relapse. We are also investigating if people in recovery from anxiety disorders have a similar tendency to think the worst about possible anxiety symptoms. We also want to find out if there are any links between being worried about your mental health, being afraid of having a relapse and catastrophising about possible symptoms.

Why is this important?

By understanding more about how relapse might happen, this study hopes to help inform ways to reduce people's likelihood of relapse. If our hypothesis that people think the worst about possible symptoms of their previous mental health problem is true, then treatment and techniques to manage worry and anxiety could help prevent relapse.

Use of language about mental health

We are aware that some of the language used in this study such as 'mad' or 'crazy' may be upsetting or stigmatising towards people with mental health problems. Although the main

University of Bath
Department of Psychology
Tel: 01225 383251
Rebecca Sired
r.sired@bath.ac.uk

researcher is uncomfortable with this language, it was important to include mainstream terms to tap into what people might think if they were catastrophising (thinking the worst) about their mental health getting worse. The 'Experiences Interpretation Questionnaire' was designed with input from people with personal experience of mental health problems, particularly around the language used.

Whilst some words in the questionnaires such as 'relapse' and 'mental illness' may be associated with a medical model of mental distress, there are other ways of thinking about these experiences. This leaflet from MIND provides more information about psychosis: https://www.mind.org.uk/media/519359/understanding-psychosis-2013.pdf

What if I want to know more?

If you would like to find out more about the study or have concerns please contact the main researcher, Rebecca Sired, in the first instance (r.sired@bath.ac.uk, 07808617926). You can also speak to one of the supervisors of the project:
Dr Emma Griffith (University of Bath), e.j.griffith@bath.ac.uk
Professor Paul Salkovskis (University of Oxford), paul.salkovskis@hmc.ox.ac.uk
Dr Taruna Jamalamdaka (Clinical Psychologist, AWP), t.jamalamadaka@nhs.net
Dr Kate Chapman (Clinical Psychologist, AWP), kate.chapman2@nhs.net

Where can I get support?

If you are experiencing psychological discomfort or distress after taking part in this study, then please contact your GP for advice or support. If you are receiving support from mental health services, you can also contact your care co-ordinator or your local crisis team.

Other sources of support:

- The Samaritans provide free, independent, confidential 24/7 support on **116 123** or email: jo@samaritans.org
- SANE provide emotional support, information and guidance for people affected by mental illness on **0300 304 7000** (daily, 4.30-10.30pm)

Thank you for again for your participation in this study

Second part of the study *(online responses only)*

We would like to invite some people to take part in the second part of this study. This would involve completing one of the questionnaires again and take about 10 minutes. If you agree, we will email you a link to this second part in a few weeks and you can decide whether or not to take part then. Your data from this first part of the study will only be linked to your responses to the second part by a unique code word you choose, and all responses will remain confidential and anonymous. Your data will not be linked to your email address,

University of Bath
Department of Psychology
Tel: 01225 383251
Rebecca Sired
r.sired@bath.ac.uk
V2: 26/10/18
IRAS ID: 241705

which will be kept separately and securely on a password-protected file and deleted once you have been sent the invitation email.

Are you happy for us to contact you about the second part of the study?

Yes ☐ No ☐

Please enter a unique code word below. To protect your anonymity please do not include any personal information such as your name, address or birthday. You will need to remember this and enter it at the beginning of the second survey *(only displayed if answered yes)*

.....

Please follow this link to provide your email address. *(only displayed if answered yes)*
<weblink to separate qualtrics page to enter email>

Appendix T: Normality of Data

The data were checked against the assumptions of parametric statistical tests before analysis. Normality of continuous variables was considered using histograms, P-P plots, z-scores, Kolmogorov-Smirnov test and skewness and kurtosis scores. These indicated positive skew for anxiety (GAD-7) and depression (PHQ-9) for all three groups and negative skew and kurtosis for functioning at worst (WSAS-worst) for the two MH groups. Additionally, the EIQ external-control subscale data (psychosis group only) showed positive skew, and the psychosis-like subscale (anxiety group and control group) and anxiety-like subscale (control group only) showed positive skew and kurtosis. Log10, SQRT and reciprocal transformations were performed but unsuccessful in correcting deviations from normality and the potential loss of power associated with their use was deemed unacceptable (Field, 2013), therefore all analyses were performed on the raw data.